The Modern Hospital

AUGUST 1961

Technician drawing off plasma in sterile room of Michael Reese Blood Center (P. 87).

How to give your hospital a better thermal environment and save money

Thrift, as well as quality, is evident in the modern facilities of Wesley Hospital, Wichita, Kansas.

Air conditioned throughout, the hospital is equipped with a specially planned Johnson Pneumatic Control System. Individual room thermostats automatically maintain the exact temperatures required for patients' health and comfort. In addition, Johnson Humidity Control is installed in the emergency room, the operating floor, and the maternity building. A recently completed intern-resident apartment building is also equipped with a Johnson System.

Johnson Control adds greatly to efficiency at Wesley Hospital. It results in better patient care, saves time for and contributes to the productivity of the staff, and helps minimize fuel and power consumption. And it will do all this at a lifetime cost below that of any other type of control.

With costs so important in modern hospital management, it will pay you to investigate the superior performance and economy features of Johnson Pneumatic Control. Ask your architect, consulting engineer, or Johnson representative for the facts when you build or modernize. Johnson Service Company, Milwaukee 1, Wisconsin. 110 Direct Branch Offices.

JOHNSON CONTROL

PNEUMATIC SYSTEMS

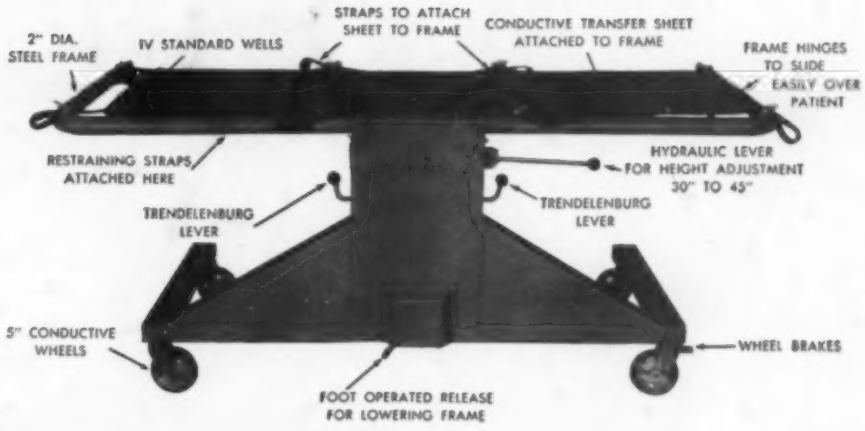
DESIGN • MANUFACTURE • INSTALLATION • SINCE 1885

Wesley Hospital, Wichita, Kansas. Forsblom & Parks and Thomas, Harris, Calvin & Associates, architects; E. E. Hysom & Associates and Thomas, Harris, Calvin & Associates, mechanical engineers; Martin K. Eby Construction Co., Inc., general contractor; Pray Brothers, Inc., mechanical contractor; all of Wichita.

NEW! HAUSTED TRANS-LIFT

EASIER, SAFER, MODERN

way to transfer patients



Prevent:

- **Injury or discomfort to patient**
- **Strain or injury to nurse**
- **Compensation Cases**
- **Delays**

Merely place the patient on the TRANS-LIFT conductive sheet — from then on there's no lifting, rolling or disturbing the patient.

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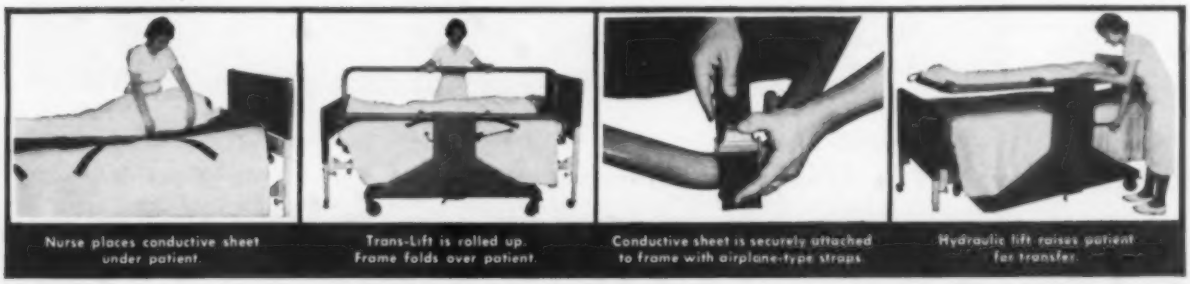
One tiny nurse lifts patient (up to half a ton) with hydraulic lever, rolls unit to wherever desired and lowers patient effortlessly to bed, surgery table, X-Ray table, etc.

Thoroughly hospital tested, the Trans-Lift, like all Hausted hospital equipment, assures years of trouble-free service.



Nurse places conductive sheet under patient. | Trans-Lift is rolled up. Frame folds over patient. | Conductive sheet is securely attached to frame with airplane-type straps. | Hydraulic lift raises patient for transfer.

For complete details on Hausted Trans-Lift, ask your Simmons Contract salesman or Hausted representative for a live demonstration in your hospital.

SIMMONS COMPANY
HAUSTED DIVISION

For additional information, use postcard facing back cover.

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The Modern Hospital

AUGUST 1961 VOLUME 97, NO. 2

Continued on next page ▶

The Modern Hospital

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MEDICINE AND PHARMACY

FOOD SERVICE

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HOUSEKEEPING

REGULAR FEATURES

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READER OPINION

Industrial Technics Are Means, Not End

Sirs:

The articles on central service planning in the March 1961 issue played down one basic question that should be analyzed in such planning, *i.e.* whether the hospital should engage in repetitive industrial operations under the guise of providing sterile supplies.

The articles discuss many other industrial concepts, such as industrial engineering and assembly line technics, effectively and rather appropriately, since there are some factories smaller than the central service layouts described.

A valuable tool for the administrator, purchasing agent, and central service supervisor to adopt is known in purchasing management as the "made or buy" study. . . .

None of us can rationally support building a small factory within the hospital. We do realize that for every repetitive production task we impose upon ourselves, there are usually two or more industrial sources that can do it better, cheaper and more responsibly. Better includes the fruits of management under the profit motive, and the operation of quality control systems with higher reliability. Cheaper includes the cost of total annual demand compared with the quantity discount schedules of leading supplies; cheaper means supplied in ready-for-use packaging with no "make ready" costs unknowingly assumed by the institution; and cheaper means that hospital space, supervisory talent, and executive attention are freed for patient care activities and management of medical resources.

We look toward the day when objective factors other than cost come into the disposables and reusables equation — morale, welfare and safety of the patient and staff, and elimination of drudgery associated with clean-up of reusable items. Then central service will be restored to its primary functions: first, the distribution of sterile supplies to nursing units; second, the distribution of pooled equipment to all users; third, custom-made production of instruments, linens and supplies, as kits for certain surgical procedures; and fourth, to perform other tasks in direct support of patient care which are related to the first three and cannot be assumed by other departments, *e.g.* cannot be obtained from responsible suppliers.

A searching exploration of alternatives is a function of an executive. At a time when air conditioned hospitals cost $40 per square foot to construct, no one is discharging his responsibility to the community when he participates in converting hospital space to factory operations with only historic trends and local emotional attitudes as his guide. The expertise that the staff has developed in industrial management technics is a means to the ends of patient care. Enthusiasm for industrial management technics should not be permitted to expand to the point where industrial enterprises are established in order to be managed.

Maj. Leo J. Collins, USAF, M.S.C.
Washington, D.C.

(*Continued on Page* 8)

(*Continued From Page 6*)

Be Careful of Label, 'Industrial Tool'

Sirs:

Since the article "Differences" that appeared in "Looking Around" in the May issue of The MODERN HOSPITAL touched on methods improvement, I was much interested.

Reactions to the thesis that adoption of some concepts and methods of industry is warranted in the hospital field range from "we work with people, not things" to violent emotional outbursts about the "efficiency expert." I do not think there is much point in contending with such attitudes.

Our experience would indicate that we should avoid such discussions completely, particularly in talking of methods improvement. In the development of our own work simplification program we were assisted by consultants from Sears Roebuck & Co. In their presentation they pointed out that work simplification had worked well in industry and now we wanted to apply it to hospital activities. Many of their examples, films and teaching aids were industrially oriented. For some of our hospital people this was rather traumatic.

We recessed our training efforts until we were able to develop our program with a hospital orientation. With the assistance of the Sears Foundation we participated in making a series of hospital work simplification training films. With this development we again offered our training programs. Since that date we have not mentioned the fact that work simplification is an "industrial tool." We teach that this is a program which will help to improve patient care. The fact that industry also uses it to help its work effort is not particularly germane.

I believe this to be a practical response to the facts as they are. If hospital people react to industrial references, let us not make them. The important thing is that the technic will help us in improving hospital operations. It is merely informational that these technics are also helpful in industrial activities.

I am completely in accord with the thesis that business methods can be adopted and adapted to the hospital field. I do react, however, to the emphasis on *industrial* or *business* technic when attempting to convince hospital people of their applicability. I feel this unnecessary and conducive to untoward reactions.

Carl T. Heinze
Administration Office
Research and Educational Hospitals
University of Illinois, Chicago

L.P.N.'s Are Not 'Aides'

Sirs:

When reviewing the suggested plans for staffing nursing departments, "Four Nursing Patterns Fit Smaller Hospitals" (April 1961), we, as coordinators of an approved school preparing practical nurses who are eligible for licensure, differ strongly with the author's interpretation of the functions of the practical nurse.

Practical nursing has grown very rapidly in the last 15 years. Fifty states and the territory of Puerto Rico now have a law to license practical nurses. A licensed practical nurse who has graduated from an approved

the Ames idea: through simpler diagnostics... standardized results... manpower savings

There is no panacea for those universal hospital problems—rising costs and shortage of skilled help. But for many hospitals, a step in the right direction has been adoption of the AMES idea: the simpler the procedure, the less chance for costly error in execution and interpretation.

With this idea in mind, AMES through research has pioneered and perfected a growing line of *standardized* diagnostic products. The most rigorous *quality control* during every phase of production assures the *uniformity* and *reproducibility* of results that hospitals require.

In routine urinalysis, AMES Reagent Tablets are so simple to use that untrained as well as trained personnel obtain the same dependable, standardized results. The newer AMES Diagnostics are based on an even easier "dip-and-read" technique. And from one to three determinations can be made with one reagent strip.

Since there is no preparation of solutions or clean-up afterward, and these tests are actually performed in seconds, skilled technicians are freed for more demanding tasks.

Your AMES representative will welcome an opportunity to explain how AMES Diagnostics can achieve standardized results and save time and money in your hospital.

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school has had 12 months of instruction in theory and supervised practice in order that she may understand the underlying principles involved in nursing care. A nurse's aide, however, is a person who is taught *on the job* to perform certain nursing skills but who has very limited or no knowledge of principles. It was with astonishment that we discovered Miss Jensen, in her job descriptions to clarify duties of nursing service personnel, identified the practical nurse as being synonymous with the nurse's aide with no differentiation in their nursing duties. There is a place on the nursing team for a nurse's aide, but if the role of the trained licensed practical nurse is understood by the team leader who makes the arrangements, the duties of these two will not be the same.

Lucile Broadwell
Coordinator
Monica Haffler
Assistant Coordinator
Marion Lennan
Assistant Coordinator
Practical Nursing Center
Chicago

Author's Reply

Sirs:

The article in question was an excerpt and condensation from the forthcoming book, "Nursing Service Manual for the Small Hospital." The parts printed by The MODERN HOSPITAL did not refer to relative merit of personnel discussed, but were intended as a guide for best usage of the categories of personnel discussed.

The author had assumed (I hope not erroneously) that any person using the guide would recognize the fact that licensed practical nurses are preferable for the stronger positions than trained aides. However, as pointed out, qualified personnel for the small hospital, particularly in some areas, is in very short supply and the small hospital often finds itself in the position of having to train its personnel for positions. The article attempted to show how this might be done to advantage and the use of the terms "practical nurse" or "trained aide" was meant to show that a trained aide could be used in the position if a practical nurse were not available. It was not meant to imply that these terms are synonymous.

I quote on that subject from the "Nursing Service Manual" as it will appear in book form: "Many practical nurses who are licensed by their states become so following a set period of actual nurse aide experience in a hospital. So it can be readily seen that the great pool of nonprofessional nursing help comes from the public at large. In those instances where there are licensing standards dependent upon actual, practical nursing school certification, the licensed practical nurse can have a place in the staffing scheme midway between the professional nurse and the trained aide, depending upon her individual merit. . . . Whatever the program for licensing practical nurses in your state, you can actively promote this program to your own hospital's benefit. Recognition by your hospital of earned status will enhance general morale. . . ."

Fauntella T. Jensen
Owner-Administrator
Casa Maria Nursing Home
Tucson, Ariz.

Design Decides Savings

Sirs:

Congratulations to Architect Herbert P. McLaughlin for his frank and honest statements on circular hospital design (Are Circular Units Overrated? May 1961, p. 81).

The cost of patient care must be reduced or controlled. This can best be done by starting with the initial design and construction, with consideration to provide better patient care through sound and economical engineering that will actually reduce the cost of operation and maintenance. The increase of total square feet per bed in new hospitals is a major factor in housekeeping, plant operating, and maintenance high costs. Some of this increased floor area can be credited to better service facilities and requirements by public health authorities. However, a large percentage of this increased floor area is wasted due to fads which have no practical application whatsoever, such as the circular units. . . .

If we are going to spend $20,000 to $30,000 per bed, then we should have a hospital that will reduce the cost of operating and maintenance, thus providing better patient care at a reduced cost per patient day. With architects analyzing and thinking like Mr. McLaughlin, this can be, and has been, accomplished.

J. A. Millard, P.E.
Hospital Consulting Engineer
Lima, Ohio

How Dial Soap can help curb the staph problem in your hospital

In vitro tests demonstrate Dial's extraordinary effectiveness

Routine use by personnel and patients suggested as aid in eliminating one source of infection

The antibacterial ingredient in Dial—a synergistic combination of hexachlorophene and trichlorocarbanilide—has long been known for its effectiveness against the skin bacteria that cause perspiration odor.

Now, new and more extensive tests have established that Dial inhibits the growth of a wider range of gram-positive and gram-negative bacteria—including strains that are resistant to antibiotics—than any other leading toilet soap.

Many physicians already recommend the use of Dial to their patients. And now, this new evidence points up, even more sharply, the benefits of Dial for hospitalized patients and hospital personnel.

Costs no more than other popular soaps . . . comes in three hospital-tested sizes

With its uncommon antibacterial benefit you might expect to pay extra for Dial—but you don't. Trim costs more by choosing bar sizes suited to your hospital. Available in hospital-tested sizes: 1, 1¾ and 2½ oz.—also others. Write our laboratory at address below for technical and clinical information.

1. Ordinary toilet soap left this heavy growth of Staphylococcus aureus.

2. A widely-used antiseptic soap showed little inhibition of Staphylococcus aureus.

3. Dial soap completely inhibited Staphylococcus aureus.

FROM THE INDUSTRIAL SOAP DIVISION OF ARMOUR AND COMPANY 1355 W. 31st Street, Chicago 9, Illinois

Public Relations

These Ideas Put 'Dash' Into Routine Communication Problems

By Gordon Davis

GET a roll of white wrapping paper at the dime store. Hang it from a sawed-off broom stick or a piece of pipe. Write your messages on it in bright colors with felt-tipped marking pens.

Gordon Davis

Stage a lobby or window display of the typical headgear or footwear of every class of employe in your hospital. Label it "Who Wears These Hats?" or "Who Fills These Shoes?" and then explain who.

Instead of issuing a special piece of literature, buy newspaper space to print the same story and order a liberal quantity of reprints for wide distribution.

If your hospital is in an appropriate age bracket, celebrate your anniversary with a community-wide search for natives born on your founding date and share your birthday with them.

Calculate how many thousands of dollars worth of equipment is used by the typical patient, and see that each patient is made aware of the amount.

If you must publicize rising charges for your services, be noisy about your increasing costs — payroll increases, additions to work force, higher expenditures for equipment and supplies.

Putting a little dash into your public relations jobs in this fashion not only adds fun to them, it does a great deal to break down the natural apathy that is the first barrier to community understanding of your hospital.

Imagination is, of course, a rare and at times an almost priceless asset. Those who display it to a sufficient degree rise quickly to the top in advertising, merchandising and the arts. Their incomes make a tax-happy Uncle Sam chortle and rub palms with glee.

But the habit of using the imagination can be acquired by almost anyone. It comes in part from taking a second look. Look twice or thrice at your annual report, your patient booklet, your employe publication, the outline of the speech you plan to make, the wording, color and visual impact of a poster designed for your lobby or bulletin boards.

Can they be made different, more interesting? Would it help to replace some of those routine-sized photographs with big, full-page dramatic shots? How about colored paper stock for a change? How about running a broad red band down one side of a plain white booklet cover? Stick dime store decorations on some of those home-made bulletins. Relate those dry-as-dust statistics to things people know and use — hours of work, packages of cigarets. Use teasers. Use change of pace. Yes, even make an intentional mistake where it won't hurt, and then ostentatiously correct it.

As in the old story about clubbing the mule, you gotta get their attention before you can educate 'em. And you need their attention these days. Few institutions have as complex a job of public education as the hospitals. If you lull your community to sleep with routine or perfunctory reporting, blame not your fellow townsfolk for failing to understand your problems, support your needs. ■

NOW—an exciting new hospital product from Colgate-Palmolive Research!

COLEO

the soap that

REDUCES SKIN BACTERIA— GIVES DEODORANT PROTECTION PEOPLE WANT!

Available in 1, 1½ and 3-oz. sizes, unwrapped for greater convenience.

Developed by Colgate-Palmolive Research, new COLEO Anti-Bacterial Deodorant Soap with T.C.S.A. is winning tremendous acceptance with hospitals everywhere. A high-quality toilet soap, new COLEO—

- ★ **Used every day, it reduces skin bacteria . . . gives deodorant protection, too!**
- ★ **Inhibits bacteria on soap itself.**
- ★ **Lathers freely in hot or cold, hard or soft water.**
- ★ **Is non-toxic, non-irritating . . . has a pleasant fragrance.**
- ★ **Distinctive yellow color for ready identification.**

WRITE for free descriptive booklet with detailed test results.

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SAFETY KEYED
Each service outlet has a separate plug-in adapter that's absolutely non-interchangeable. Color-keyed for each service handled too. Tamper-proof plugs available.

ANY COMBINATION
Single, double or triple outlets are now available. Soon: 4-service outlets. Choose any combination of services.

FLUSH MOUNTED OR EXPOSED
Flush-mount for built-in installations. Exposed units for modernization. Adapters for each service are interchangeable between flush mounted and exposed type outlets.

PRACTICAL
No wheeling of tanks. Plugging in or disconnecting is a one hand operation. Long-lived nylon pawls reduce friction. Stainless steel plates are durable, easily cleaned.

ACCESSORY BRACKET
Holds vacuum bottle, gauge and control valve in true vertical position for reliable operation.

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Flush outlets are mounted in standard electrical wall boxes. Twelve inch copper, lead-in tubes are silver soldered to check unit bodies, ready for connection.

Be sure you have Schrader Safety-Keyed Gas Outlets in your piped system installation. Write for complete details including illustrated technical literature.

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just insert the INCERT®
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Eliminates "the use of the traditional, and potentially hazardous, syringe-needle method..."* in parenteral therapy.

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Note these findings:

"The Incert System of disposable vials reduces . . . air-borne contamination . . . to a minimum . . ."*

". . . the disposable vial system minimizes the potential transmission of infectious hepatitis."*

"There is greater accuracy in delivering a pre-measured quantity of medication."*

*Bogash, R. C.; DeLa Chapelle, N.; Sowinski, R., and Downes, D.: Disposable Type Vials for Adding Medications to Large Volume Parenterals, Am. J. Hosp. Pharm. *17*:104 (Feb.) 1960.

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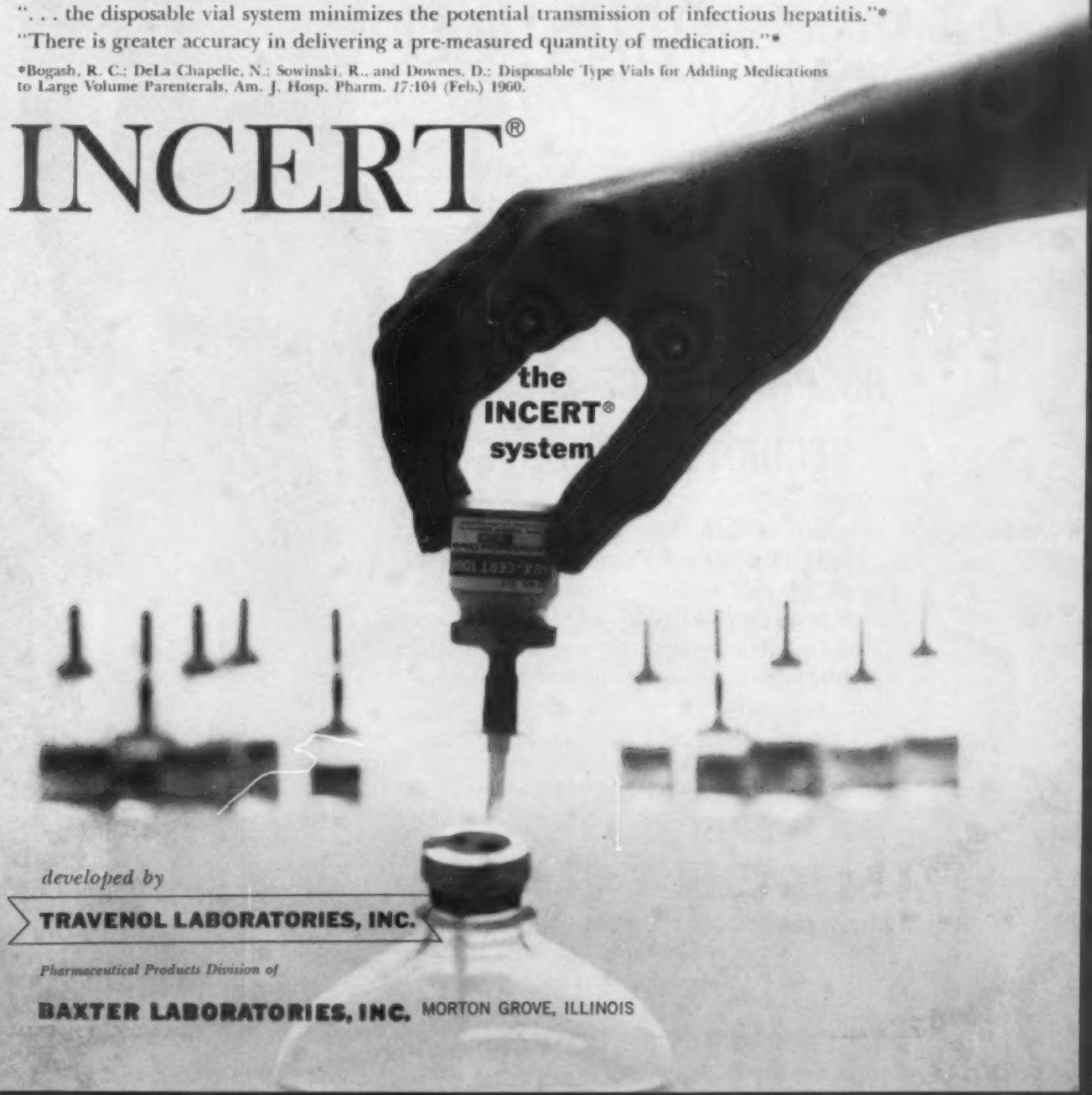

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NOW—A NEW STANDARD OF HILOW BED
VALUE, SAFETY AND EFFICIENCY

HILL-ROM ANNOUNCES:

THE HILL-ROM no. 68 ALL-ELECTRIC HILOW BED

LISTED UNDER RE-EXAMINATION SERVICE UL UNDERWRITERS' LABORATORIES, INC.

*Contour Position

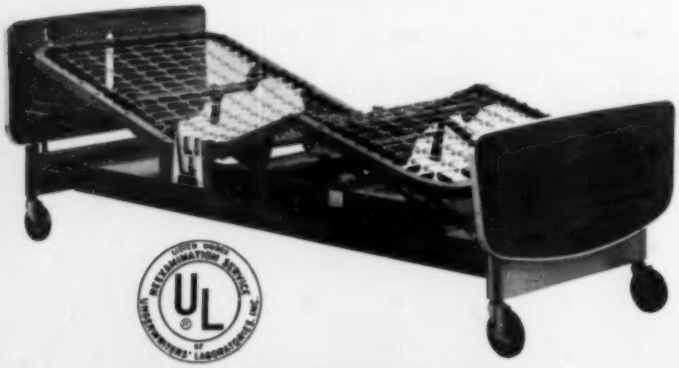
Here's how HILL-ROM'S new no. 68 All-Electric Hilow Bed will help you to:

NO. 68 ALL-ELECTRIC HILOW BED—MADE UP. Note the clean, sturdy appearance. Head and foot boards have a refreshingly new contour, with edges covered with extruded anodized aluminum trim. The bed is permanently lubricated with oilite bearings. There are six locations for the IV rod, with a storage tube under the head section. Legs are recessed at foot end to prevent doctor, nurse or attendant from tripping when moving around the bed. The National Fabric bottom is more buoyant and resilient, for greater patient comfort. The Trendelenburg spring gives any required position.

LOWER MAINTENANCE: Fewer electrical parts mean less maintenance. The new No. 68 bed has only five (5) electrical parts: 2 condensers, 1 Thermal, and 2 switches. Think what this means in your daily operation! You are reassured that the work load of the maintenance department is kept at a minimum. And, your patients will be spared frequent annoyances.

EFFICIENT, CONVENIENT CONTROLS: Fingertip controls mounted on both sides of the outstanding No. 68 hilow bed for easy access of patient and nurse. Any height—any spring position—may be had at the touch of a finger. Controls can be de-activated in any position by recessed, bump-proof cutout levers.

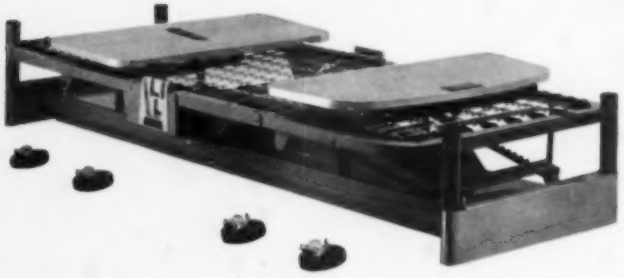
EASIER CLEANING: Head and foot sections elevate to all required positions. There are no obstructions such as sharp edges or racks to impede thorough cleaning. All operating mechanism is fully enclosed in a trim, secure, welded center channel, the top of which can be quickly removed. Cleaning is easy—and complete!



TOTALLY ENCLOSED MECHANISM: The entire mechanism is completely enclosed in a welded steel center channel, which has a removable cover to give quick access for checking vital parts. The totally enclosed mechanism also makes for quicker, easier and more complete cleaning.

Safety at a new all time high
Maintenance at a new low!

BELOW—READY FOR SHIPMENT: This illustration shows the No. 68 bed ready for shipment. The bed is factory assembled and *thoroughly tested.* Insert casters, mount the ends, plug in to electric outlet and the bed is ready to use.



1 *provide better patient care*

2 *reduce maintenance*

3 *simplify housecleaning*

4 *improve room decor*

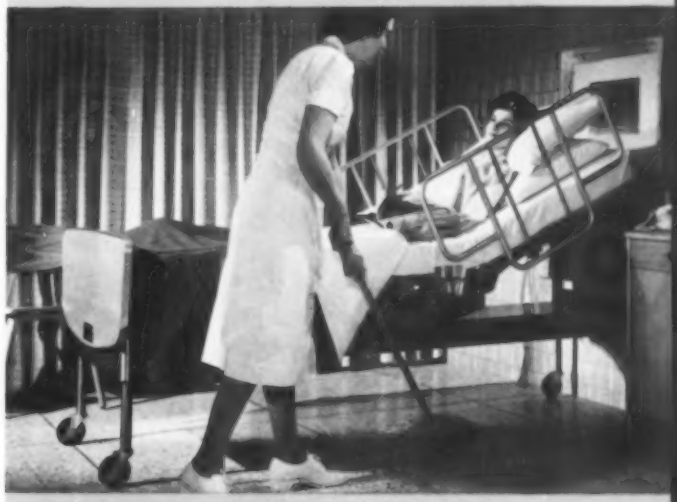
LOW AND MANEUVERABLE: Large (5″) ball bearing casters used as standard equipment. In low position top of spring to floor is 17″. In high position top of spring to floor is 26″.

REFRESHINGLY NEW DESIGN: Bed ends have a pleasing contoured styling. All exposed metal parts of foot end and inner legs are covered with stainless steel. Mops and floor machines will not chip off paint, ordinarily used. The edges of all end panels are protected with extruded anodized aluminum trim.

BETTER PATIENT CARE: Nothing is more gratifying to you than the parting words of a recovered patient—"I had such good care!" With the new Hill-Rom No. 68 all-electric hilow bed you can give better patient care!

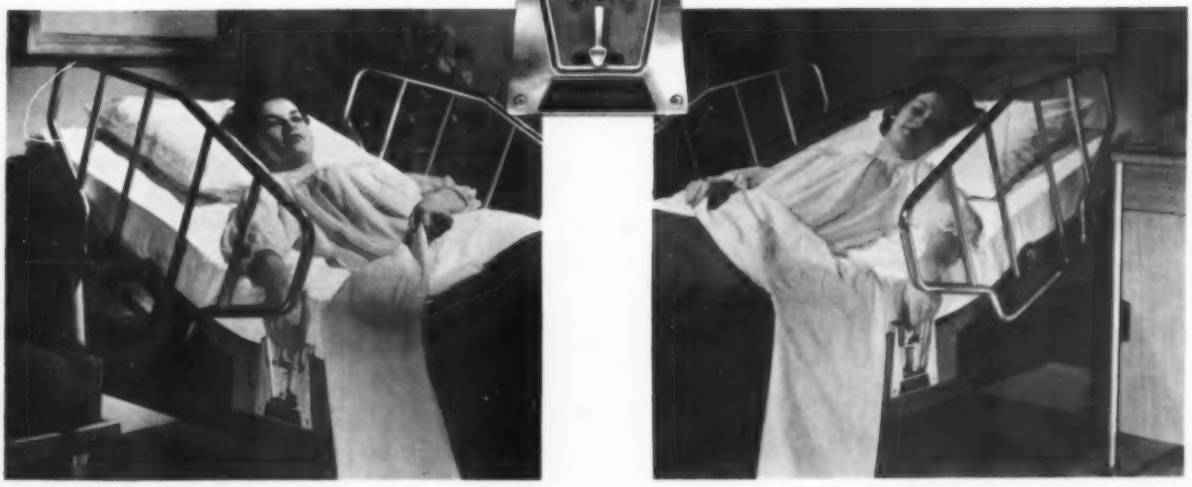
HILL-ROM CO., INC., BATESVILLE, IND.

SPRING AND MATTRESS FOLD TOGETHER: The entire spring and mattress assembly folds into a compact, upright position to permit quicker, easier and more complete cleaning. The entire mechanism is completely enclosed in a welded steel center channel.



EASIER, QUICKER CLEANING: No stooping necessary when mopping the floor because the spring has no lower rail. The swipe of a mop will not damage the stainless steel apron. Inner legs are also protected with stainless steel. No paint to chip.

Controls are located on both sides of bed.



Above, left: Patient using right hand to operate controls.

Above, right: Patient using left hand to operate controls.

Patient safety is your first concern . . .

and here is the safest hospital bed available

Hill-Rom's concern with patient safety is no recent matter. Back in the days before hilow beds came into such general use, Hill-Rom developed a Safety Step that was widely accepted and used, and which was instrumental in substantially reducing bedfall accidents that were so frequent then with patients getting into and out of high hospital beds. Years ago Hill-Rom developed Safety Sides, the original short side guards that have so amazingly reduced bedfall accidents wherever they have been used.

When Hill-Rom developed the first all-electric hilow bed it was not offered for sale until after it had been listed by Underwriters' Laboratories, Inc. for use with oxygen administering equipment. The same policy has been followed with the No. 68 bed. Hill-Rom offers this new all-electric hilow bed in full confidence that it is the safest hospital bed available. It should be kept routinely in the low position, except when treatment or nursing care is being given the patient. In low position the spring is approximately the same distance from the floor as the patient's bed at home. This, in itself, is an important factor in reducing bedfalls.

Statistics show that bedfalls account for a high percentage of all accidents within hospitals. The patient forgets that the bed is higher than the one at home. Stepping out to a lower floor level than he is used to often causes a patient to lose his balance and fall. This No. 68 all-electric hilow bed, with Hill-Rom Safety Sides attached, will help reassure your patients—and reduce bedfall accidents.

The No. 68 All-Electric Hilow Bed is listed by Underwriters' Laboratories, Inc., re-examination service, for use with oxygen administering equipment.

Bed is raised to a height most convenient to permit patient to adjust to crutches.

HILL-ROM CO., INC., BATESVILLE, INDIANA

The Finish is part of the Floor

Without proper surface treatment hospital floors become hazardous underfoot – dirt traps develop – cleaning becomes difficult – floors become a source of infection and sooner or later expensive floor replacement is necessary.

Hillyard Surface Coatings and Finishes, tailored for each type of floor, become an integral part of the wearing surface – fill dirt catching pores and pits, make floors repel dirt and remain aseptically clean longer.

Hillyard Hospital Floor Cleaners are specialized. Each is formulated for safety and savings –

safe – meet highest requirements for sanitation or asepsis.

safe – meet special requirements, such as conductivity, non-slipperiness, non-flammable.

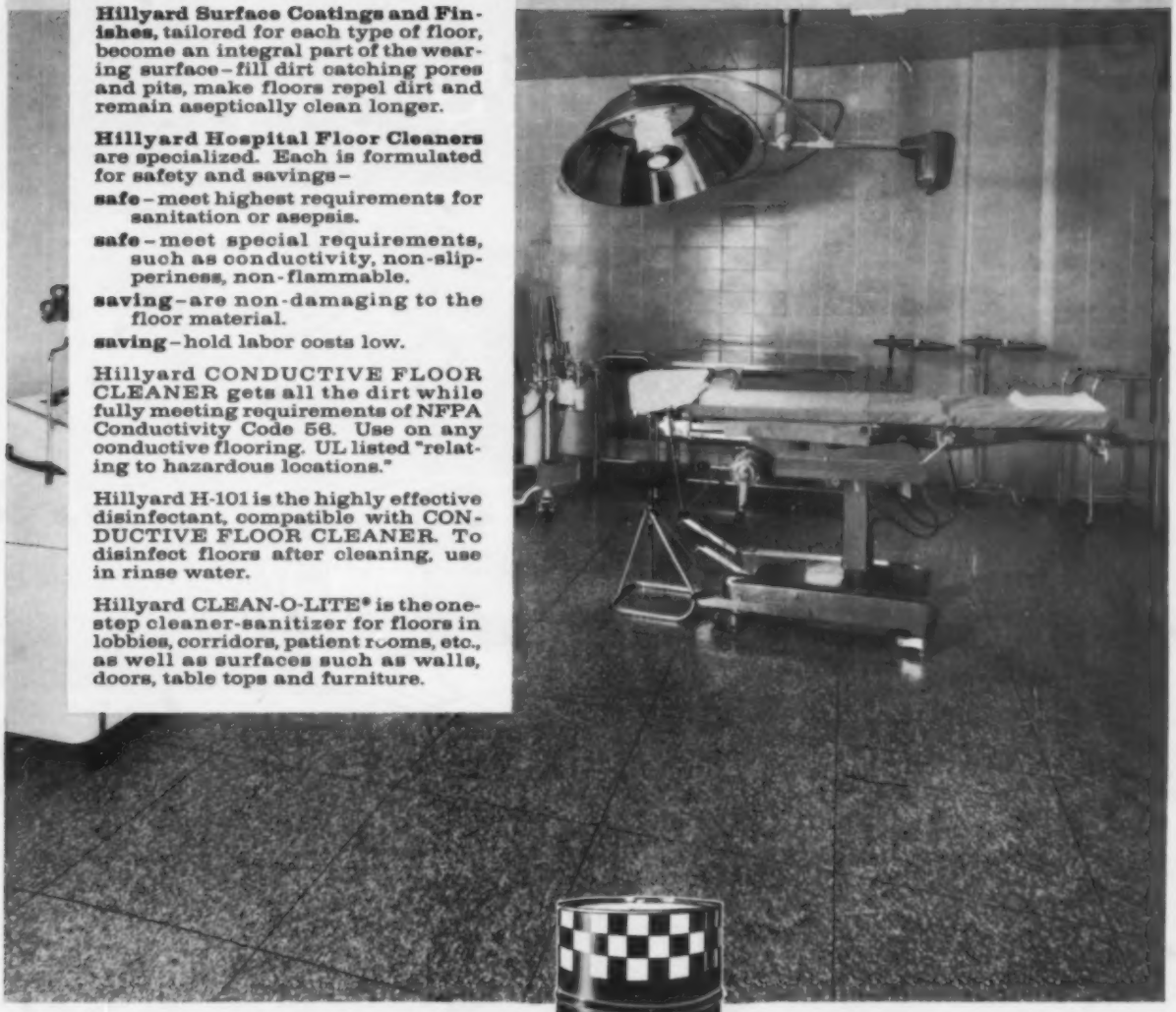
saving – are non-damaging to the floor material.

saving – hold labor costs low.

Hillyard CONDUCTIVE FLOOR CLEANER gets all the dirt while fully meeting requirements of NFPA Conductivity Code 56. Use on any conductive flooring. UL listed "relating to hazardous locations."

Hillyard H-101 is the highly effective disinfectant, compatible with CONDUCTIVE FLOOR CLEANER. To disinfect floors after cleaning, use in rinse water.

Hillyard CLEAN-O-LITE® is the one-step cleaner-sanitizer for floors in lobbies, corridors, patient rooms, etc., as well as surfaces such as walls, doors, table tops and furniture.



Let the Hillyard Hospital Floor Care Consultant give you technical advice on safe and economical Hospital Floor care. He's

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Since 1907

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IN THE THE HOSPITAL...

You'll *Finish* Ahead with

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These advanced AMSCO sterilizers....

The sterilizers shown on these pages embody nearly 70 years of investigation dedicated to the development of ever-new and better hospital techniques and equipment.

In serving the phenomenal strides of medical science, the American Sterilizer Company is honored to have pioneered virtually every advancement in the field of sterilization during the 20th Century.

The modern sterilizers presented here are tangible evidence of but a few Amsco achievements in the area of advanced hospital sterilizers for the 60's. Each in its own way is supremely efficient . . . possesses great speed and versatility with the dependability expected of Amsco.

Yet . . . tomorrow Amsco's research facility will yield new techniques and new equipment for hospitals in every country of the free world. For our dedicated purpose is constantly to seek the better way.

Illustrated brochures are available on all Amsco Sterilizers for the 60's. Write for the copies you would like.

VACAMATIC HIGH-SPEED CENTRAL SERVICE STERILIZERS

- High pre- and post-vacuums with 275°F. steam permits ultra-fast cycles . . . full load of linens complete in 15 minutes.
- Fully automatic controls.
- Handsome exterior design.
- Water Ring Vacuum Pump with *Air Ejector for dependable* high vacuum.

- *International Amsco Subsidiaries:*
  AMSCO CANADA LIMITED — Brampton, Ontario, Canada
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world's hospitals to new heights of patient protection in the 60's

LABORATORY STERILIZERS

- Cyclomatic and Isothermal Controls perform Inspissation, Pasteurization, Fractional Sterilization and Pressure Steam Sterilization procedures.
- Ideal for processing heat-sensitive or heat-coagulable media and fluids.
- Square chambers . . . recessed and cabinet mountings.

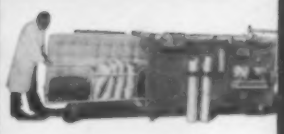
MODEL M. E. RECTANGULAR STERILIZERS

- Long recognized as the "workhorse" of Central Service.
- Ideal for solutions, dressings, utensils, instruments, milk formula and laboratory supplies.
- Fully automatic Cyclomatic Control.

Also available as a utility M. E. with enameled exterior

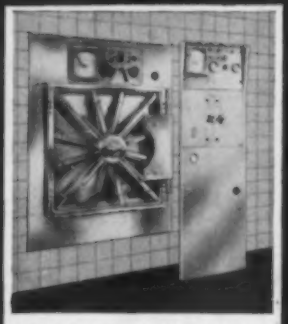
CRYOTHERM "COLD" STERILIZER

- For "cold" gaseous sterilization or heat- or moisture-sensitive materials, instruments and pre-packaged supplies.
- Ideal for Urology, Surgery, Central Service, Pharmacy and Laboratory.
- Cryoxcide gas supplied in 16-pound cylinders.



MATTRESS AND BEDDING DISINFECTOR

- Especially designed for decontaminating mattresses, blankets, pillows, bassinettes, incubators, etc.
- Ample microbial factor to kill STAPH or the communicable disease pathogens.
- Ethylene oxide sterilant for 37"x46"x88" vacuum-pressure chamber.



COMBINATION GAS-STEAM CENTRAL SERVICE STERILIZERS

- Ideal for sterilizing heat- or moisture-sensitive equipment and supplies.
- Dual, fully automatic controls.
- May be used 24 hours a day.
- Adaptable to any ethylene-oxide mixtures.

INSTRUMENT WASHER-STERILIZER

- For Sub-sterilizing Rooms or Central Instrument Clean-up.
- Choice of three automatic cycles:
  1. Wash and sterilize
  2. 3-min. sterilizing cycle at 270° F.
  3. 7-min. sterilizing cycle at 250° F.
- 11"x11"x24" chamber.

SQUARE PRESSURE STERILIZERS

- Designed for Surgical Supply, Milk Formula and Pressure Instrument applications . . . with minor modifications for each use.
- Square chambers increase load capacity.
- Fully automatic Cyclomatic Control.

CYLINDRICAL STERILIZERS

- Cyclomatic Control assures correct sterilizing cycle.
- Single or double wall chambers.
- Wide choice of sizes . . . open or recessed mounted.
- Economical initial cost.

World's largest designer and manufacturer of Sterilizers, Operating Tables, Lights and related equipment and supplies for hospitals

AMSCO

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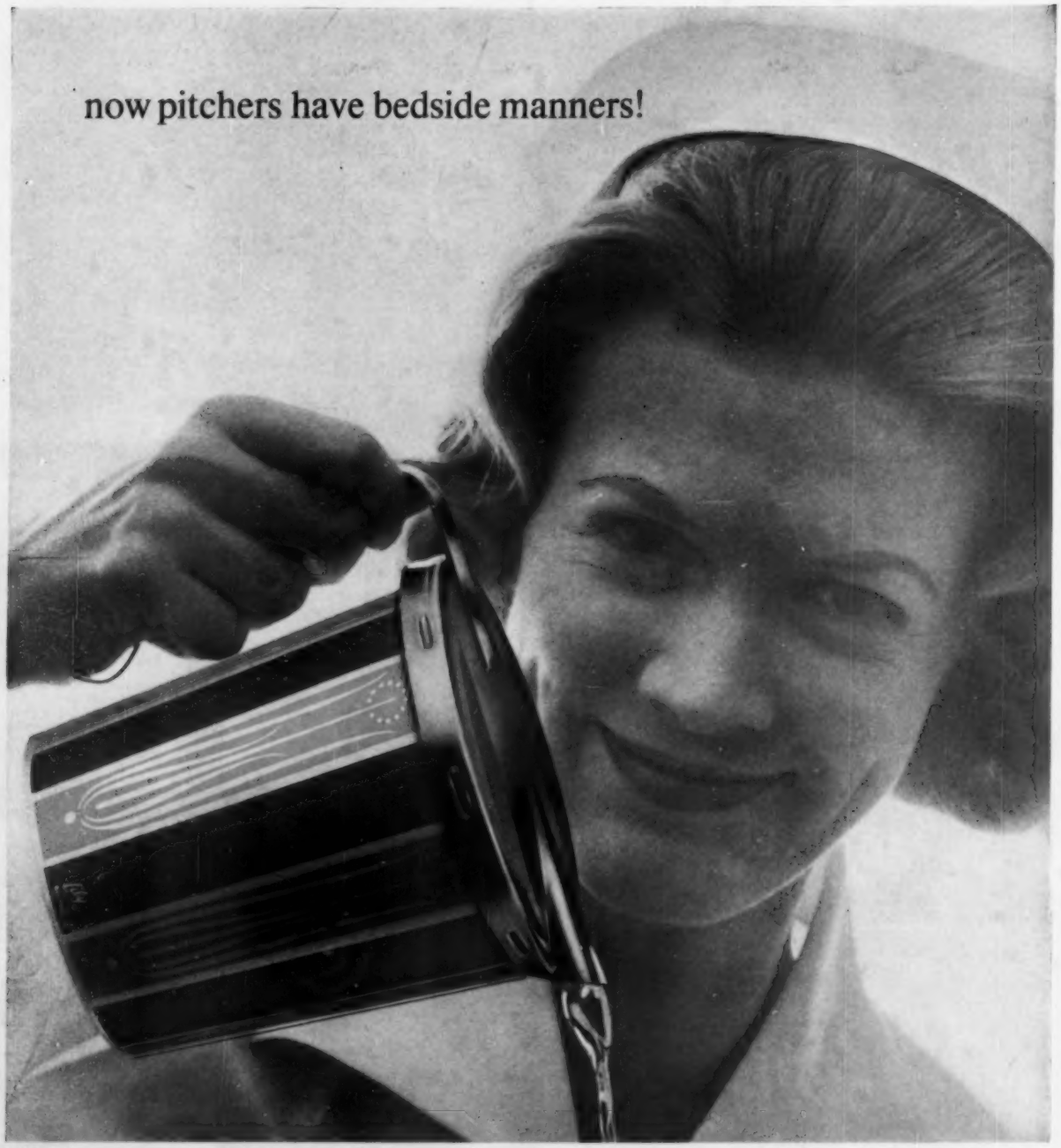

Lily cures your hospital water service problem

FROM LILY MARKETING COMES A CAREFUL DIAGNOSIS OF HOSPITAL WATER SERVICE PROBLEMS AND THE SOLUTION ...A SANITARY, DISPOSABLE PITCHER, ESPECIALLY DESIGNED TO IMPROVE YOUR BEDSIDE BEVERAGE SERVICE

■ Lily® comes to the aid of hospital water service with a beautifully designed water pitcher that makes bedside beverage service a pleasure for both patient and nurse. ■ This handsome disposable pitcher holds a quart of liquid, yet is lightweight and easy to handle when full. The specially designed stainless steel lid snaps on and off easily, provides for patient identification, lets liquids pour freely, keeps ice in. Because it is paper, the pitcher is a natural insulator, keeping water cool and fresh for hours. ■ Choose this distinctive design to match the complete "Tulip" design place setting—or select the famous Lily Green Leaf design. There are matching water cups that put the finishing touch on sanitary water service. ■ For additional information, write to: Lily-Tulip Cup Corporation, Box MH861 122 East 42nd Street, New York 17, N. Y.

Quixams®: Made for Emergency Room Economy

Every easy-on-and-off Quixam fits either hand; saves sorting and handling time; reduces costs where usage is greatest. Quixams are only one of the complete line of PIONEER Rollpruf Surgical and Hospital Gloves — all designed for positive savings on specific jobs. A PIONEER Glove Expert can help you save by making a complete analysis of your glove problems.

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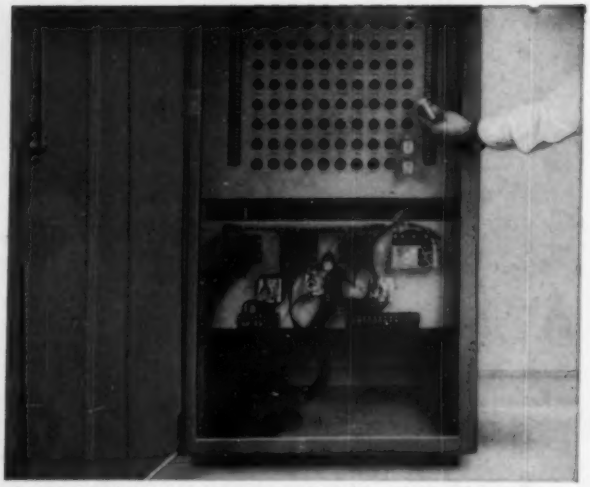
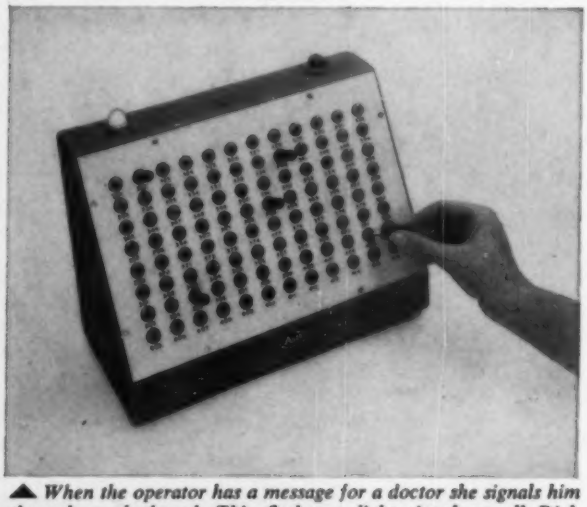
▲ *Doctors—entering and leaving—dial 3-digit code numbers on small Dial-Registers placed at convenient locations—then press the IN or OUT button.*



▲ *Their IN-OUT status is transmitted by electrical impulses to the control center. There the information is stored for release to any IN-Former which interrogates it.*

▲ *IN-Formers are used by the telephone operator and others to check any doctors' IN-OUT status by dialing his code number. Colored lights reveal his status.*



▲ *When the operator has a message for a doctor she signals him through a plugboard. This flashes a light signal on all Dial-Registers as he dials himself IN or OUT.*

"DIAL-IN"

—*the Best Doctors' In-and-Out Register System for Large Hospitals*

This unique new staff register system is really a boon to large hospitals. When a doctor is urgently needed much time can be saved—perhaps a life—by knowing immediately and reliably whether or not the doctor is in the hospital. In large-staff hospitals with a number of entrances—or a number of buildings—the problem of registering the coming and going of doctors has defied a satisfactory solution. Up to now conventional register systems have required too much space; too much installation expense; too much inconvenience and time-loss to doctors and hospital personnel. Now, the Auth "Dial-IN" system eliminates these obstacles and makes it possible for large-staff hospitals to know who is in within a few seconds—and it does this conveniently for everyone and at reasonable cost.

The "Dial-IN" System and other types of doctors' in-and-out register systems; nurses' call systems; and doctors' paging systems—all designed to increase the efficiency of your hospital—are manufactured by AUTH. A representative is ready to discuss them with you. No obligation, of course.

Auth SINCE 1892

Auth Electric Company, Inc.

LONG ISLAND CITY 1, NEW YORK

SPECIALISTS IN HOSPITAL SIGNALING AND COMMUNICATION SYSTEMS, CLOCK AND FIRE ALARM SYSTEMS

Armosol, the result of four years of exhaustive research, is a liquid synthetic cleaner and disinfectant that kills bacteria and deodorizes as it cleans. Armosol is particularly designed for hospital and institutional use where bacterial and fungal control are of prime concern.

Eight nationally advertised products of the Armosol type were thoroughly tested and compared with Armosol. The best *cleaner* of these fell far short of Armosol's efficiency. The best *germicide* was considerably less effective.

How it is used:

Armosol effectively cleans, sanitizes and deodorizes using the ordinary cleaning techniques, sponge, mop, floor machine, spray or flood. Armosol is also useful for cleaning refrigerators, stoves and other equipment as well as in the preliminary cleaning of surgical instruments.

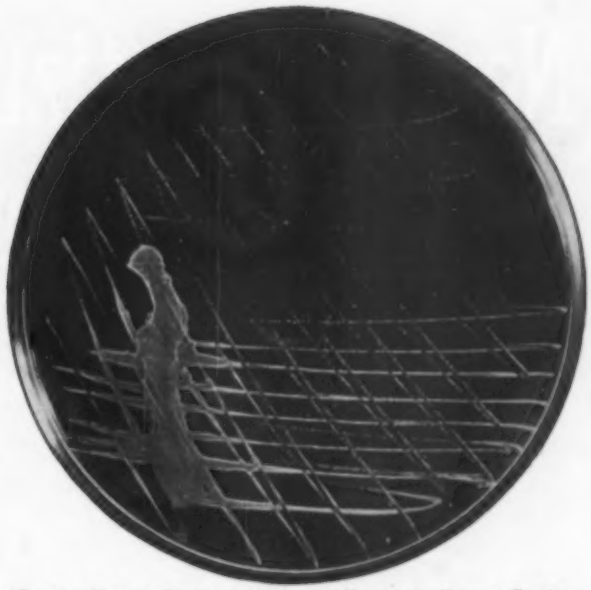
It is economical:

Armosol is odorless, readily soluble in both hard and soft water, non-staining, and is gentle to hands. It does three jobs at once—cleans, sanitizes and deodorizes. At the recommended concentration of 1½ ounces per one gallon of water, Armosol will clean and sanitize approximately 1500 square feet of surface. One gallon of Armosol makes 85.3 gallons of solution, or enough to clean about 127,950 square feet at an average cost per day of 1¼¢ per patient.

Environmental Sepsis Control:

Armosol, together with Dial Bar, Dial (Hexachlorophene) Surgical Liquid Soap, and Velva-Soft-G (anti-bacterial fabric finish) for all laundered linens, now helps provide a practical program for environmental sepsis control in hospitals and institutions.

For technical information please write: B. J. Augst, Manager, Industrial Soap Division, Armour and Company, 1355 West 31st Street, Chicago 9, Illinois.



"In vitro" tests demonstrate Armosol's extraordinary effectiveness. The untreated plate above shows profusely growing Staphyloccus before treatment. The second plate clearly shows the complete inhibition of growth of S. aureus after application of Armosol at recommended use dilution.

Phenol coefficient: Using the A.O.A.C. Phenol Coefficient Method (revised—1955) Armosol has a guaranteed minimum rating of 14 against *S. typhosa* and 25+ against *S. aureus*. Although newer tests have revealed that the phenol coefficient alone is not an adequate criterion of disinfection, Armosol's rating is superior to any of the eight leading similar products.

Other tests: Using the Use-Dilution Confirmation Test (1953) which measures the kill at actual use levels, Armosol showed complete kill at 1:80 dilution against the test organisms, *S. choleraesuis* and *S. aureus*. The Chambers/Weber & Black Hard Water Tolerance Test (1958) was also used. Armosol destroyed 99.999% of these bacteria in water with a hardness of 500 ppm at the same dilution—and in just 30 seconds!

ARMOUR AND COMPANY **INDUSTRIAL SOAP DIVISION**

Now! 2 appetizing foods make serum cholesterol control easier, more effective than ever!

Your Patients Can Enjoy Fine Foods With Minimum Diet Changes!

For good eating while maintaining serum cholesterol control

Leading authorities agree that where reduction of serum cholesterol levels is indicated, fat intake should not exceed ⅓ of total calories and of this, at least ⅓ should be polyunsaturated fats.

Polyunsaturated fats, such as those found in corn oil, are rich in the linoleates which are important in reducing serum cholesterol levels. This has been proven time and again in nutritional studies of hypercholesterolemia.

Mazola Margarine and Mazola Corn Oil have outstanding P/S (polyunsaturate to saturate) ratios. Thus the hypercholesterolemic patient can usually enjoy the same appetizing foods as the rest of the family.

Mazola Corn Oil is unexcelled in polyunsaturates and lowest in saturates of all leading brands of vegetable oils. Mazola's P/S ratio is far higher than that of any other leading food oil. Your patient will find Mazola Corn Oil ideally suited for salad dressings and frying; also for baking wherever *liquid* shortenings are called for in the recipe.

Mazola Margarine* contains *liquid* Mazola Corn Oil as a major ingredient. This corn oil is not hydrogenated, thereby preserving its rich content of linoleates. Mazola Margarine contains 2 to 3 times as much natural linoleates as any other margarine readily available in grocery stores from coast to coast. Its taste, color and handling characteristics are unexcelled.

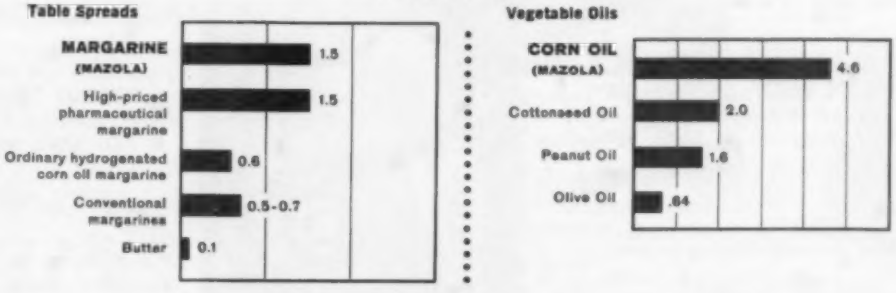
*U.S. Pat. No. 2,955,039

AVERAGE COMPOSITIONS OF MAZOLA® MARGARINE AND MAZOLA® CORN OIL
(All figures are in grams.)

	MAZOLA MARGARINE		MAZOLA CORN OIL	
	100 grams	2 oz. (4 tbsp.)	100 grams	1 fl. oz. (2 tbsp.)
Fatty Acids				
Polyunsaturated	21	12	51	14
Monounsaturated	40	23	32	9
Saturated	14	8	11	3
Natural Sitosterols	0.5	0.3	1	0.3
Natural Tocopherols	0.08	0.045	0.08	0.020
Cholesterol	none	none	none	none
Sodium	0.9	0.5	none	none

MAZOLA MARGARINE—410 Calories/2 oz.; Iodine Value—96
MAZOLA CORN OIL—250 Calories/fl. oz.; Iodine Value—124

RATIO OF POLYUNSATURATES/SATURATES
(Average values.)



CORN PRODUCTS COMPANY 10 East 56th Street, New York 22, N.Y.

NEW! BLICKMAN-BUILT!®

TOUCH-n-GO® VARIABLE SPEED POWER DRIVE

Optional factory installed extra for all NEW FOODVEYORS®

... ends grunt-&-groan pushing ... pays for itself effortlessly!

Just TOUCH the power bar and GO ... in and out of elevators, around corners, up and down steep hospital ramps. It's easy!

Say goodbye to the backbreaking era of hand-maneuvered food conveyors ... Touch-n-Go makes them as obsolete as the horse-and-buggy!

Touch-n-Go provides positive, velvet-smooth power that works quietly and swiftly without mechanical linkages, drives, gears, chains or belts.

Stops are smooth ... braking is automatic as the power bar is released. And there's a brand-new safety bumper that turns power off automatically on contact with any object.

GET FULL PARTICULARS...MAIL COUPON TODAY!

Touch-n-Go Division
S. BLICKMAN INC.
1508 GREGORY AVENUE
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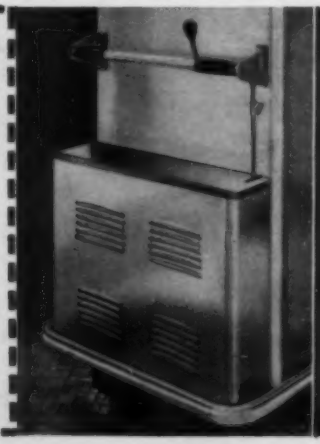
GENTLEMEN:
Please send immediately, at no obligation, complete details on Touch-n-Go Foodveyors.

HOSPITAL .....
NAME .....
ADDRESS .....
CITY ..... ZONE .... STATE .....



FROM THE MOMENT YOU PUT TOUCH-N-GO INTO SERVICE, YOU BEGIN TO SAVE MONEY!

- **Touch-n-Go reduces labor costs ...**
- **cuts down the number of conveyors needed ...**
- **shortens meal service time**
- **heightens personnel morale.**

NEW! LOW PRICED! COMPACT!

BLICKMAN-BUILT!

CENTRAL SERVICE FOODVEYORS®

Compact design clears the deck... more work area... total visibility! Complete refrigeration system between hot and cold compartments!

Traditional Blickman quality plus many new features now bring you Hot-&-Cold Foodveyors that deliver piping hot, crispy cold meals . . . more palatable than ever before! Wide choice of models at prices that make them easy to own.

- **Available in 20-meal and 24-meal capacity**—lets you pick the unit that best fits your needs.
- **¼-h.p. compressor cools refrigerator down to 40° in minimum time** . . . hermetically-sealed system (no flare fittings which might leak).
- **Easy to clean** . . . interiors removable without tools.
- **Efficient electrical system** . . . conveniently located control panel—saves extra time and steps.
- **Radiant 750-watt heating system** . . . thermostatic control with ten settings—full adjustment at various heat ranges.
- **Double-walled insulated doors with positive latch** . . . seals heat in . . . no leakage between hot and cold sides!
- **Dutch doors on hot compartment** . . . retains heat during serving.
- PLUS NUMEROUS OTHER EXCLUSIVE BLICKMAN-BUILT FEATURES!!

SPECIAL FEATURE!

"Convertible" hot compartment—choose drawers or Twin-Tray feature for simplified loading and tray assembly!

SEND TODAY FOR BROCHURE WITH SPECIFICATIONS AND FULL DETAILS.

S. BLICKMAN, INC.
1508 Gregory Avenue
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Gentlemen:
Please send, at no obligation, your new 6-page Blickman-Built Foodveyor brochure.

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CITY ..... ZONE .... STATE .....

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Only Onan has solved

HERE ARE A FEW OF HUNDREDS OF HOSPITALS THAT HAVE SELECTED ONAN STANDBY POWER

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Community Hospital,
McVille, No. Dakota
Harrisburg Polyclinic Hospital,
Harrisburg, Pa.
Grace Hospital, Winnipeg, Canada
Lying-In Hospital, Providence, R.I.
Free Hospital for Women
Brookline, Mass.
Glen Lake Sanitorium,
Glen Lake, Minn.
Wesley Hospital,
Oklahoma City, Oklahoma
Perth Amboy General Hospital,
Perth Amboy, N.J.
Riverview Hospital, Red Bank, N.J.
Veterans Administration Hospital,
Madison, Wisconsin
Muscatine County Hospital,
Muscatine, Iowa
Washington County Hospital,
Fayetteville, Ark.
Scripps Memorial Hospital,
La Jolla, Calif.
Loveland Hospital, Loveland, Colo.
St. Joseph Hospital, Concordia, Kan.
Methodist Hospital, Henderson, Ky.
Confederate Memorial Medical Center,
Shreveport, La.
Caribou Hospital, Caribou, Maine
Mt. Wilson Hospital, Baltimore, Md.
Women's Hospital, Flint, Mich.
Felix Long Hospital, Starkville, Miss.
Garfield County Hospital,
Jordan, Mont.
O'Neill Hospital, O'Neill, Neb.
Huggins Hospital, Wolfboro, N.H.
Los Alamos Hospital,
Los Alamos, N. Mexico
State Hospital, Buffalo, N.Y.
New Hospital, Chapel Hill, N.C.
Mercy Hospital, Toledo, Ohio
Memorial Hospital, Stillwater, Okla.
Sacred Heart Hospital, Eugene, Ore.
Mirian Hospital, Providence, R.I.
Smith County Hospital,
Carthage, Tenn.
Kilgore Memorial Hospital,
Kilgore, Texas
Londown County Hospital,
Leesburg, Va.
Wyoming State Hospital,
Evanston, Wyo.

Shriners' Crippled Children, Springfield, Mass.

St. Lukes, Fargo, N.D.

Sister Elizabeth Kenny, Minneapolis, Minn.

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South Florida State Hospital

so many hospital standby problems

Your local Onan distributor will give you expert planning help, complete one-source responsibility for installation and service

The finest emergency power equipment is only one of many advantages you get when you specify Onan. You get these extra personal services:

Your local Onan specialist will help you determine exactly *how little* electric power you need for truly critical areas. He'll help determine the best location for your standby plant, the best cooling system, the most economical fuel supply.

Your Onan specialist will select—and supply and service—all needed accessories, including line transfer control, fuel lines, even fuel tanks.

Equally important, he'll always be available for factory parts and service locally. More than 100 authorized Onan distributors are located in major cities, coast to coast.

Onan plants, gasoline, gas or diesel driven, are now available in sizes to 230 kw. Without obligation, call in your Onan man for a free analysis of your *current* emergency power coverage and requirements. He's in the Yellow Pages. Or write for Bulletin R-235, "Factors To Consider When Installing Standby Power."

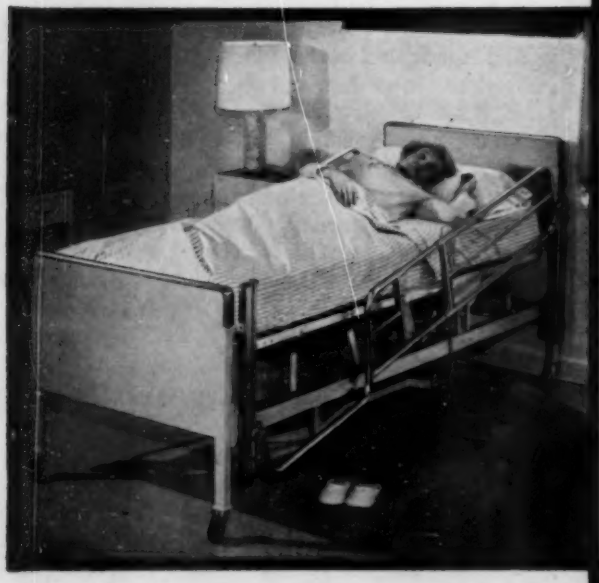
ONLY ONAN GIVES YOU THIS CERTIFICATION

World's Leading Builder of Electric Power Plants

ONAN DIVISION, STUDEBAKER-PACKARD CORPORATION • UNIVERSITY AVE. S.E., MINNEAPOLIS 14, MINNESOTA

Now...a motorized bed that costs little more than manual models

Dual-Hite by SIMMONS



FOR SITTING or reclining, the patient operates a hand-held control and selects the most comfortable posture position.

FOR SLEEPING or examination, the patient lies at a convenient nursing height, may be protected by side rails.

FOR GETTING OUT OF BED, the patient is raised to a high sitting position as the spring lowers so that the patient may place her feet on the floor with a minimum of movement.

You can have all the benefits of motorized beds at a new low cost, actually little more than for most manually operated beds. Dual-Hite* motorized beds by Simmons make no compromise with quality. The difference is a simplified principle by which the *bedspring* actually changes height.

Patients and staff benefit from Dual-Hite, too. Patients enjoy a feeling of independence when they are able to adjust the position of the bed, to get in and out without help. And staff members have more time for other duties when they do not have to change patient positions.

*Trade-Mark

SIMMONS COMPANY
CONTRACT DIVISION

Merchandise Mart • Chicago 54, Illinois
DISPLAY ROOMS: Chicago • New York • Atlanta
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Sh-h-h-!

PATIENTS SLEEPING

UNDISTURBED WHILE
DOORS OPEN AND CLOSE

ABOVE: SURFACE APPLICATION BELOW: MORTISE APPLICATION
INSTALLATION LOW IN COST MAINTENANCE IS NIL

CORBIN®

CORBIN makes the compact "400" Series Door Closers with DAC—the Delayed Action Control mechanism so advantageous in hospitals. DAC is noiseless. Foolproof. Easily adjustable to permit any door, light or heavy, to remain fully open for a predetermined period of time to allow patients or equipment to pass through before closing.

Another feature important for hospitals is the precisely-timed valve system which makes doors pause momentarily before the quiet, positive closing action takes over.

In fact, the full opening-and-closing cycle is always smooth in operation . . . positive in performance . . . and quiet as a whisper!

That's why Consultants recommend the "400" Series for hospital use, and Architects agree. It pays to make it CORBIN.

P. & F. CORBIN DIVISION
THE AMERICAN HARDWARE CORPORATION
NEW BRITAIN, CONNECTICUT

Why marco surgical dressings have proved best by test

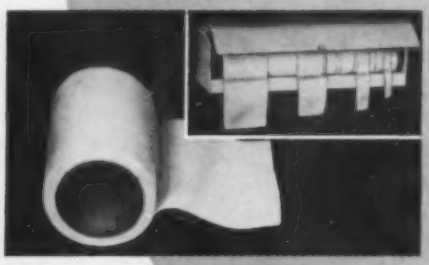
LAPAROTOMY TAPE PADS X-ray detectable, permanently bonded tape to attach to ring or hemostat. Quilted to hold shape, withstand repeated laundering. 12" x 12" or 18" x 18" square—18" x 4" or 36" x 8" oblong.

OPAKE SPONGES highly X-ray detectable element is spread throughout sponge. Non-traumatic to tissue. Bulk or pre-counted in 10's, 3" x 3" to 8" x 4".

READY-CUT BANDAGE ROLLS sealed edges prevent thread ravelling. Flip-up flap on wrapper permits one-hand removal, controls unrolling—selfsealing to keep bandage clean. 10 yards long—all widths.

marco

From raw cotton to finished product, all processing and packaging is done in our own plants, under rigid quality controls. In addition, a continuing research program is conducted to provide ever better dressings and ways of using them. For example, that's why sponges are softer and whiter, folds exact, and absorbency higher. Test Marco dressings in your own lab and compare.



ADHESIVE provides minimum skin irritation, minimum creep, no impurities. Firm fabric for wrinkle-free application, effective support. Completely usable from end to end. 10 yards ½" to 4".

STICK SPONGE all gauze, 44 x 36" mesh, ball shaped, in small, medium, large, machine made for complete uniformity in size. X-ray detectable element visible thru a *full inch.*

COTTON BALLS soft and firm, made of long-staple white absorbent cotton. Useful for perineal care, for prepping, as wipes and swabs (not sterilized). Five sizes—⅝" to 2".

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Electronic brain and jet power enable TROY FLEXIMATIC® FOLDER

To Fold Linens More Efficiently at Less Cost

AMAZING "ELECTRONIC BRAIN" controller measures linens, locates folds and directs folding in halves and quarters 100% automatically.

EXCLUSIVE JET ACTION folds with powerful jets of air to eliminate wear on linen by blade-type folders.

CUTS LABOR COSTS by replacing up to 3 receivers and folders. Simplified design reduces downtime.

NEW FOLDING FLEXIBILITY for linens 24" to 108" long and 20" to 120" wide in 1 to 6-lane models. Small piece stacker available.

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Ambulatory patients enjoy this daylighted, end-of-hall sunroom. *Thermopane* insulating glass keeps it comfortable. Faith Hospital, St. Louis, Missouri.

Made in U.S.A.

LOF GLASS

reports on a growing trend in

hospital architecture

Through large window walls, nature takes a hand in healing. We call it "open world" therapy. It's a trend in hospital architecture that is constantly growing.

Glass lets cheerful daylight and sunshine bathe each room. And from their beds patients can see blue sky and green trees.

But the patient's psychological needs must be balanced by other considerations—comfort, heating and air-conditioning economies, building mainte-

Glass-walled corridors connect buildings, look out at the open world, at Fisher-Titus Memorial Hospital, Norwalk, Ohio.
Architects: H. E. Beyster & Associates, Detroit, Mich.

Faith Hospital, St. Louis, Missouri. Associate Architects: Joseph D. Murphy and Angelo G. Corrubia, St. Louis. Windows are glazed with *Thermopane* insulating glass.

nance costs, security. Read how the hospitals shown on these pages solved their particular problems with L·O·F Glass.

YEAR-ROUND COMFORT

Thermopane® insulating glass and air conditioning are used at both Faith Hospital, St. Louis, and Roger Williams General, Providence, R. I.

Said Dr. Andrew Signorelli, founder and medical director of Faith: "People always feel better in bright, cheerful surroundings, patients particularly. No one likes to feel shut in, so through solar planning (with *Thermopane*) we've brought in lots of sunshine and opened our rooms to the view."

Resident doctors relax in daylighted penthouse lounge at Faith Hospital, St. Louis. *Thermopane* insulating glass keeps the room comfortable all year 'round.

Mr. William E. Sleight, Director of Roger Williams General, expands this opinion: "We feel that the large *Thermopane* windows contribute greatly to our pleasant and comfortable surroundings. Although we have operating sash, we never have to open them, even in the muggiest weather. In winter, when it gets down to zero, we're still comfortable near *Thermopane* windows and can enjoy the view outside. The windows don't frost up like they do in the old building."

Both hospitals are located near heavy traffic arteries, but rooms are quiet and serene because *Thermopane* effectively muffles outside noise.

LOW-COST MAINTENANCE

Insulating glass in both buildings was used also to effect heating and air-conditioning economies. On this subject

Sweeping glass façade in the new wing of Roger Williams General Hospital, Providence, R.I. Architects: Howe & Prout, Providence. L·O·F *Vitrolux* was used in the spandrels, *Thermopane* in the windows.

gives us better humidity control.

"In summer, the overhangs shut out much of the sun, shade about two-thirds of the glass, make it easier to cool the rooms. Our studies *prove* that *Thermopane* has helped us save considerably on utilities (light, heat, etc.) as compared with other hospitals of equal size."

CURTAIN WALLS

At Roger Williams General, *Vitrolux*® glass spandrels used between the *Thermopane* windows create an all-glass façade. *Vitrolux* is heat-strengthened plate glass with rich color fused to the back. It adds youthful beauty and cheerful character to the structure. Regarding the curtain walls, the architect, Donald J. Prout, has observed:

"They gave us a far more clear-cut design. They're less costly to build, and take less time to erect. Not a single glass spandrel was damaged during construction. And the glass in the windows and spandrels will keep its appearance, year after year, much better than most materials."

GLASS FOR PATIENT SECURITY

Tuf-flex® *Thermopane* is used in the psychiatric ward at McKennan Hospital in Sioux Falls, S. Dakota.

John Treacy, Chief Engineer for Faith Hospital, says:

"We air condition with hot water in winter and cold water in summer—individually controlled, room by room. The *Thermopane* windows are a great help. In winter, for instance, they let in solar heat . . . thermostats in rooms on the south side shut off one-third faster than in the others. And the lack of condensation on windows

MADE IN U.S.A.
L O F GLASS
THE QUALITY MARK TO LOOK FOR

You can see outside from any bed position in the new wing at Roger Williams General. Patients often feel "shut in" in an older room, shown on right.

This combines the insulating qualities of *Thermopane* with the strength of *Tuf-flex* for patient security. *Tuf-flex* is 3 to 5 times tougher than regular plate glass of the same thickness. And if *Tuf-flex* is broken, it is safer because it breaks into relatively small crystals.

For other windows in the new wing at McKennan, Heat Absorbing *Thermopane* (for control of sun heat and sky glare) and regular *Thermopane* were used.

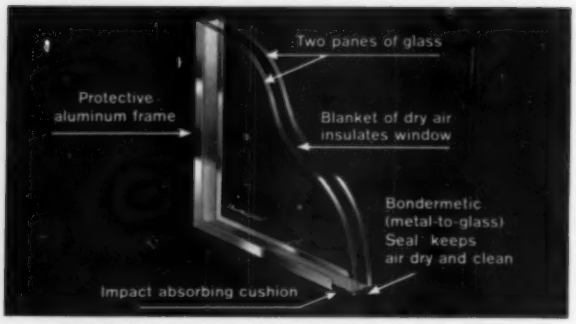
McKennan Hospital, Sioux Falls, South Dakota. Architect: Harold Spitznagel, Sioux Falls. *Tuf-flex Thermopane* is used in the psychiatric ward for comfort plus security.

MADE IN U.S.A.

L·O·F GLASS

glass for hospitals

TUF-FLEX® DOORS — These frameless, clear-glass doors can withstand, with virtually no maintenance, all the traffic they help create. Made of ¾″ and ½″ thick tempered plate glass, they are 3 to 5 times tougher than regular glass of the same thickness. Sixteen types in finished sizes up to 48″ in width and 108″ in height.



THERMOPANE®— For maximum comfort and for heating and air-conditioning economy, use *Thermopane* insulating glass in windows and sliding doors. Heat loss is cut almost in half, compared to single glazing. Drafts near windows are reduced. Frost and fogging are minimized. Outside noise is muffled. Choice of plate glass (see left below) for outer pane.

THREE KINDS OF PLATE GLASS — *Parallel-O-Plate®* is clear plate glass, twin ground for clearest vision. *Parallel-O-Grey®* is tinted neutral grey. Heat Absorbing Plate is pale bluish-green. Both *Parallel-O-Grey* and Heat Absorbing Plate reduce transmission of sun heat to keep interiors cooler. *Parallel-O-Grey* reduces glare more effectively.

VITROLUX®— Rich color, fused to the back of this clear, heat-strengthened ¼″ plate glass, adds youthful beauty and cheerful character to any structure when used as a facing material. It is resistant to weathering, crazing and checking. Also ideal for interior partitions. Sixteen standard colors, plus black and white. Standard-size panels up to 48″ x 84″.

For complete information on these and other L·O·F products, refer to Sweet's Architectural File 26-A, or call your L·O·F Distributor or Dealer (listed under "Glass" in the Yellow Pages). Or write to Libbey·Owens·Ford Glass Company, 811 Madison Ave., Toledo 1, Ohio.

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An example of Avisco Rayons in Industry

Why the medical profession is interested in new Medical grades of Avisco® rayon

Wherever they have been demonstrated, medical grades of Avisco rayon have stirred the interest of manufacturers of medical and hygienic supplies. The reasons are clear.

1. They require no cleaning to remove foreign particles.
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Tests made by a leading manufacturer of surgical dressings and bandages dramatically prove that absorbent balls of an Avisco medical grade of rayon not only absorb water faster than the traditional fiber but also maintain a constant rate of absorbency regardless of age. And the same manufacturer states that the rayon balls hold their shape, wet or dry. See for yourself why Avisco medical grade rayons are gaining rapidly in acceptance for medical-hygienic purposes. For information, send in the Quick Reply Coupon below.

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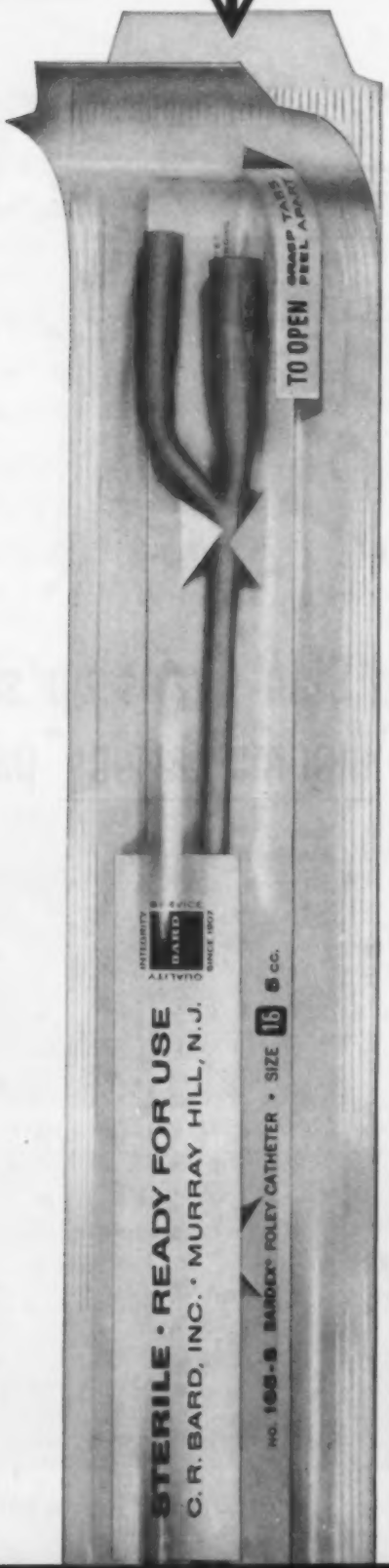

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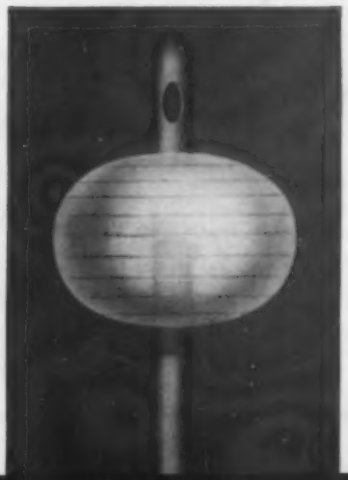

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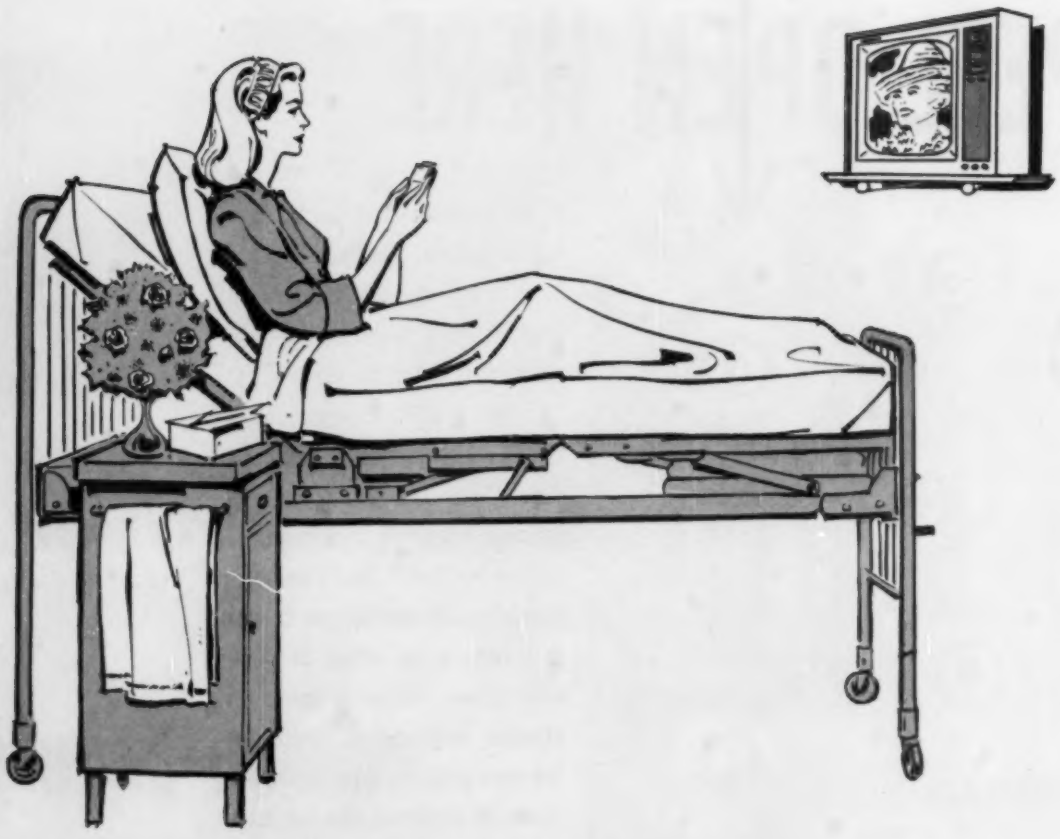

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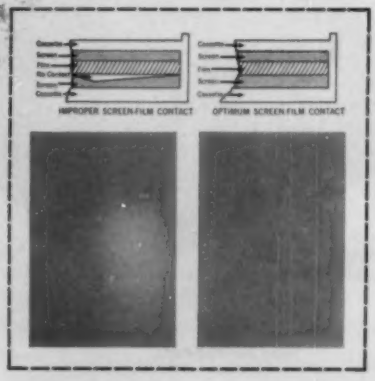
(Above) **Ansco Dura-Speed** extremely high-speed intensifying screens permit minimum patient exposure with maximum image quality with high KvP techniques. Also shorten exposure time and provide maximum detail with low capacity equipment.

(Above) **Ansco Dura-D** medium speed intensifying screens provide exceptionally fine detail at high or low KvP. Their fine grain structure is ideal for techniques requiring ultra-fine image detail. Well suited to general radiographic work.

Plus All These Other Advantages!



Better Screen-Film Contact (See illustration at left). The balanced density and thickness of Ansco's screen base material has *strength* to protect the delicate calcium tungstate layer from stress, yet is *soft* enough to allow the screen to conform to the cassette for optimum screen-film contact.

Easier Cleaning. No special cleaner needed. A damp cloth or mild soap and water solution easily removes most stains associated with screens.

Longer Life. The use of "chemical" pure materials in the manufacture of Ansco screens, plus their special non-pitting surface coating, assures long life with no recession in speed.

Consistent Quality. Ansco's exacting requirements for consistent grain size and layer thickness guarantee uniform speed ratings from pair to pair of screens.

Static Resistant. All materials used in the manufacture of Ansco Intensifying screens are selected for their resistance to static electricity.

Ansco
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How DennisonWraps make major contributions to

Efficiency of Autoclaving Procedures

Better utilization of time and space **is the constant goal of all Central Service Departments. If you're interested in measuring the efficiency of your autoclaving operation, the following questions and answers bring out valuable information.**

Q. *Why do you stress the importance of rapid drying when you compare muslin with DennisonWraps?*

A. Because DennisonWraps dry approximately five minutes faster than muslin, busy central service departments have reported an extra autoclave load per day. This faster drying feature also has a safety aspect. You may have noticed that packages removed from the autoclave often feel warm and moist, indicating the presence of steam inside. Sudden exposure of such packages to the cooler room temperature raises the possibility of condensation and contamination.

Q. *What difference does it make whether I get muslin wrappers from the laundry or DennisonWraps from the storeroom?*

A. The difference is that YOU have efficient control of your wrapper supply at all times. When you have one case of DennisonWraps in use and one in reserve, you will never run out of wrappers. Your aides and your autoclave are always efficiently employed.

Q. *Why do you say that the non-bulky nature of DennisonWraps will increase Central Supply efficiency?*

A. First, consider your storage problem. You can store three times as many DennisonWraps as muslin wrappers in a given area. The more you can store, the safer your reserve supplies.

Then, too, packages wrapped in DennisonWraps are much more compact than those wrapped in muslin. This is particularly noticeable with small items like powder packets and medicine glasses. You'll agree that you can autoclave at least 25% more per load. The more you can autoclave at one time, the greater your efficiency and the lower your cost. And you can store 25% more in a given shelf space, too.

Q. *Why do you claim that DennisonWraps increase inspection efficiency?*

A. Muslin is so porous that it must be used in two layers. So, both layers must be inspected. Only the provision of good lighting from above and below will disclose broken fibers in the muslin. Since you need only one thickness of DennisonWraps for safe sterilization and storage, double inspection is unnnecessary.

Q. *Why do you say that the switch from muslin to DennisonWraps would reduce teaching time?*

A. Because you'd be teaching a familiar technique. Every new aide knows how to wrap gifts and parcels in paper. None has ever used floppy muslin as a wrapper. So, you need only show the prescribed wrapping techniques employed in your hospital.

Q. *Doesn't the stiffness of paper make wrapping more difficult?*

A. Not with DennisonWraps. Remember, they're double-creped to produce a ribbed texture. Because of their two-way stretch, they retain their shape when folded. No need to hold them firmly to prevent them from sliding out of position as with muslin.

Q. *How would you sum up the major differences between wrapping with muslin and with DennisonWraps?*

A. Increased efficiency all along the line. Your wrappers are always under your control. Since you need not unfold each sheet of DennisonWraps, you eliminate a whole series of costly motions. Moreover, it takes less time to wrap an article in paper than in muslin because folds do not slide away from aides' fingers. And, finally, because you have the right pre-cut size for each package, no time is lost folding under excess bulk as there is with muslin.

Q. *What's the most efficient way to get started with DennisonWraps?*

A. Get a free hospital evaluation kit and use it to conduct comparative tests. It contains DennisonWraps in the most-used sizes and forms: sheets, glove wicks, envelopes and cases, plus hospital reports on the safety, economy and efficiency of DennisonWraps. Ask your local hospital supply house . . . or address your request to Dennison Manufacturing Co., Dept. V-9, Framingham, Mass.

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insist on reusable

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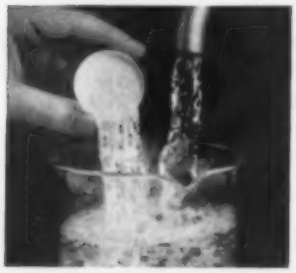
. . . identified by their exclusive hygienic imprint.

"...organisms are completely destroyed... The results indicated Warexin to be a satisfactory cold sterilizing agent"*

ACHIEVE TRUE COLD STERILIZATION, PREVENT CROSS-INFECTION, MAINTAIN HOSPITAL ASEPSIS...WITH WAREXIN

WAREXIN: A monoxychlorosene derivative containing an organic hypochlorous acid in a phosphate buffer. In useable concentrations it has a pH range of 7.4 to 7.8.

Warexin is lethal to fungi, bacteria, viruses, resistant spores, in less than 1 hour. Yet it is non-toxic, non-irritating to hands, and will not stain or discolor.



A true cold sterilizing agent, Warexin can be mixed with ordinary tap water; does not require distilled water.

Economical — sterilizing solution costs approximately 27¢ a quart.

Can safely be used for: instruments of stainless steel or other widely used corrosion-resistant alloys . . . complex equipment such as artificial kidneys, etc. . . . articles of rubber, plastic, non-porous fibers, glass, porcelain, enamel . . walls, floors, tables, etc. . . . pre-operative skin preparation.

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* Engelhard, W.E., Weidman, J.G., and Jolliff, C.R.: Evaluation of Warexin as a potential cold sterilizing agent, Surgery, 49: 651-656, 1961.

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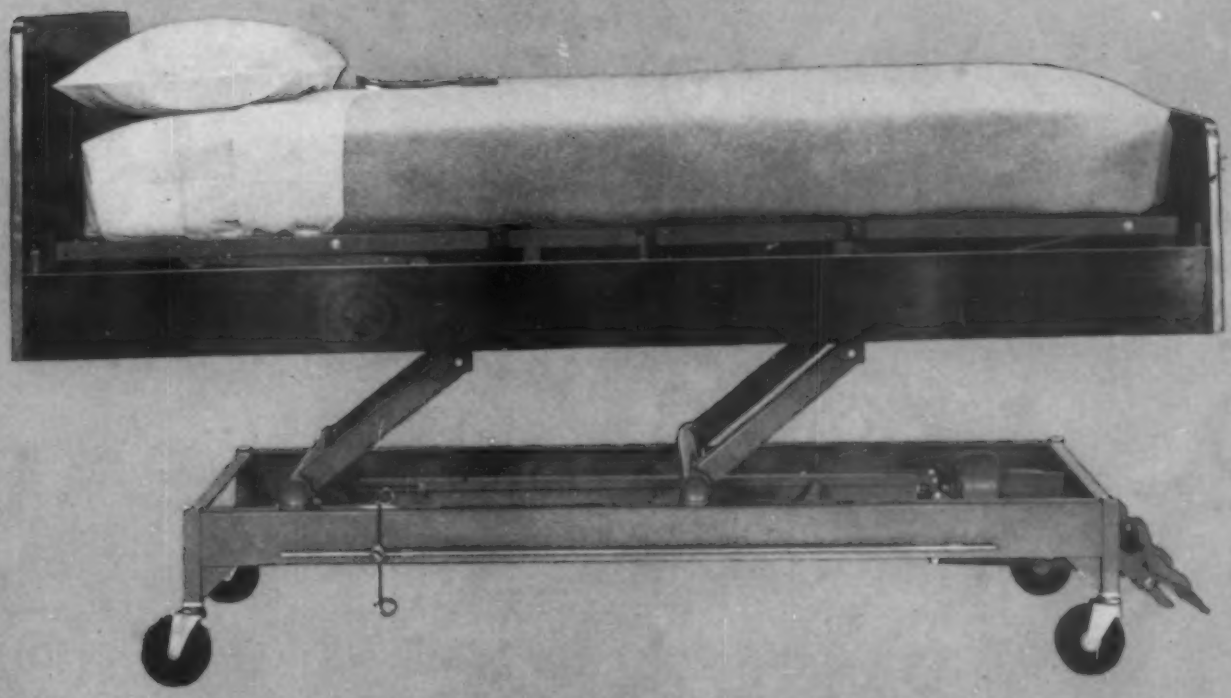
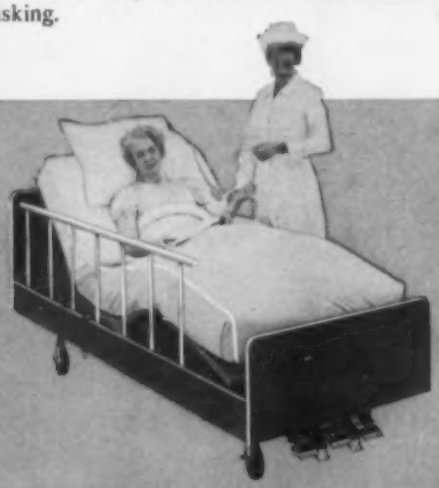


This is the motorized bed that raises to FULL 34-INCH STRETCHER LEVEL

This is the new, fully motorized Borg-Warner hospital bed. It incorporates every feature we could think of to add to your convenience and efficiency. One example is its stretcher level high position. Not just 26 inches. Nor only 30 inches. But a full 34 inches from floor to top of spring sections. This is four to eight inches higher than any other motorized bed. It means quicker, easier, gentler transfer of patients from bed to stretcher, and back again. Other features of the Borg-Warner bed are equally notable. Including the cost, which is 20% to 30% less than other fully motorized beds. Full details are yours for the asking.



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Prove to yourself how a TRUMATIC Folder will immediately cut labor costs and increase production in your laundry department. Call your nearby American representative, or write for Catalog AH 7[illegible].

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Tucson Medical Center Community Hospital, Tucson, Ariz.

SMALL HOSPITAL QUESTIONS

What Chiropodists Can Do in the Hospital

Question: We would like to ask about the legality of a chiropodist or podiatrist writing on the charts. In the booklet issued by the Joint Commission on Accreditation of Hospitals, it says, "a podiatrist may not admit patients to the hospital under his name. He may not prescribe medications or write histories and physicals."

We have a difference or absence of opinion in our staff. Some of the doctors insist that the podiatrist write his own routine orders and they will not. They add the medications and so forth and sign for them. Is this considered legal?

Also the Joint Commission booklet says that the podiatrist must have a physician in attendance when doing surgery on an inpatient, but not necessarily when doing surgery on an outpatient. In our hospital all the surgery done in this category is minor.

Is not surgery still surgery, regardless of the classification of the patient? Who signs the operative record?

We would appreciate any advice you can furnish regarding these problems.—E.J.H., Mich.

ANSWER: It is well understood in the medical profession and in hospitals that the chiropodist or the podiatrist is a technician, and that if he has privileges in a hospital he must function under the surveillance and supervision of a doctor of medicine. As with any technician, he may not admit patients or write orders for patient care. He is not qualified to write the history or physical examination, nor check the heart and lungs of a patient before anesthesia, nor can he prescribe drugs in the preoperative or postoperative periods.

I agree with you that surgery is surgery and that there is no justification for the classification of "minor" surgery. Therefore, it is my firm conviction that a doctor of medicine must be in *actual attendance* when the chiropodist performs a surgical procedure, regardless of whether it is on an inpatient or on an outpatient.—ROBERT S. MYERS, M.D., *Executive Assistant Director, American College of Surgeons.*

What Should Nursing Notes Include?

Question: What are the legal requirements of other states in regard to the material to be included in daily nursing notes in the patient's chart?

Our procedures committee is in the process of revising our charting methods and we are interested in what can legally be deleted from our present procedure for daily nursing notes.—N.S., R.I.

ANSWER: There is little legal authority on this point.

Hospital licensing laws refer to nurses notes as a part of the medical record, but in no state is there a detailed discussion of requirements as to the content of such notes. Licensing regulations do not spell out any legal requirements.

Several judicial decisions have alluded to nurses notes and from these it is possible to formulate a rule that a failure to keep adequate nurses notes on a patient would be negligence, if this failure resulted in the patient's injury. However, even this rule does not state with any exactitude the entries that must be made — just that nurses notes must be kept and that they must be adequate.

In the absence of specific legal requirements, you must be guided by what would be considered to be good nursing practice in your community with respect to inclusion or exclusions in nurses notes. This requires that you examine the practices in your community and area, and determine as well what constitutes good practice and conform to it.

This is the standard that will be applied by the courts and liability can ensue when practice falls below this standard. Thus, the burden is squarely on the hospital to examine its present policies and formulate methods in the future that have high standards, as you conceive them.—JOHN F. HORTY, *Director, Health Law Center, University of Pittsburgh.*

Urge Nursing Home Visits

Question: Should the visiting hours and regulations for the nursing home be the same as for the hospital?—D.K.A., Ohio.

ANSWER: They should be as liberal as possible. The Public Health Service, in "Nursing Home Standards Guide,"* recommends:

"Patients in nursing homes should be encouraged to maintain contact with their friends and relatives outside the home. The nursing home should, therefore, make known to all concerned its rules and regulations governing visiting hours. They should be as liberal as possible.

"Special consideration should be given to seriously ill patients. No home should otherwise restrict an individual patient's visiting privileges unless instructed to do so by the attending physician for medical reasons."

*Available from the Superintendent of Documents, Washington, D.C., for 45 cents.

No List of Aide Programs

Question: Can you furnish a list of the hospitals and schools conducting the surgical technical aide programs described in Operating Room Forum in June?—B.B.H., Ore.

ANSWER: To the best of my knowledge, such a list has not been compiled. Many hospitals are attempting to teach the course on the job and their success has varied with the quality of the instruction and the availability of facilities, time for teaching, and motivation of the hospital.

Baylor University Hospital, for example, conducts a formal program about eight months in length for licensed practical nurses who want to specialize in operating room work.

Another such program is conducted annually at Thayer Hospital, Waterville, Me., and is open to aides, maids, orderlies and practical nurses. It is an intensive five-week program. The program content follows the guide I wrote for the American Hospital Association, "Surgical Technical Aide, Instructor's Manual," which is available from the A.H.A. headquarters.

This manual is written in outline form. For more complete content material, I would suggest a review of "Operating Room Technique" written by Erline Perkins, published by the Saunders Co.—FRANCES GINSBERG, R.N.

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ESTES KEFAUVER PUTS A.M.A. ON STAND

Chairman Kefauver's drug price show is on the road again — but this time it has a spotlight on the American Medical Association as well as on the manufacturers of prescription drugs.

Supporters of the controversial Senator Kefauver say his objective is simply to force the manufacturers to do less promoting of doctors and put less emphasis on trade name drugs, thereby, the senator believes, automatically lowering the prices patients have to pay at the drugstores. The senator's critics say that in the first place he primarily is on a hunt for headlines, and that even if he were sincere his proposed new drug controls wouldn't ensure lower prices but would ensure less research, thus depriving the public of many valuable drugs.

American Hospital Association hasn't entered the case yet, but is preparing a statement for Senator Kefauver's antitrust and monopoly subcommittee. There is some possibility Senator Kefauver will require A.H.A. to produce a witness, under threat of subpoena. Whatever happens, A.H.A. won't be a target for the subcommittee. Its testimony, following official policy of the association, will explain the value and safety of hospital formularies and indirectly put in a good word for generic names. This fits in perfectly with the chairman's ideas on how the prescription drug industry should be run.

The hearings will continue intermittently through the summer and into the fall, with the A.M.A. never far off the scene.

Senator Kefauver set up the A.M.A.'s problem when he called association witnesses for early July hearings. He followed this up later in the month by putting on the stand medical and pharmacy teachers, pharmacology researchers, and medical practitioners who defended Senator Kefauver's bill as reasonable and effective and fired alternate blasts of criticism at the A.M.A. and the drug industry.

A.M.A. witnesses, headed by Dr. Hugh Hussey, Georgetown medical dean and chairman of the association's board, were faced with these interlocking charges at the first set of hearings:

Since 1905, when the association helped to get the first pure food and drug law through Congress, the A.M.A. has been progressively reducing its efforts for the study of drugs and for the policing of drug advertising claims. It was pointed out that up to 1950 brand names could be used in A.M.A. publications only by the inventor of a new drug, but that this restriction was dropped, with the implication that the objective was more advertising. (A.M.A.'s explanation is that the task of determining the real inventor was too complicated.) Also, Senator Kefauver's staff noted that A.M.A. stopped publication of a booklet, "Useful Drugs," and shut down both its microbiologic and chemical laboratories.

But, in the eyes of the subcommittee staff and Senator Kefauver, the real conspiracy started unfolding in 1955.

In that year the A.M.A. dropped its seal of acceptance, awarded by the Council on Drugs to ads meeting its standards for A.M.A. publications. Thus, while the council still was consulted on drugs, its importance diminished.

In the years following this action, the subcommittee was able to show that advertising increased substantially in the *Journal of the American Medical Association* and the association's other journals. The implication was that advertising standards for drugs were dropped so the publications would bring in more revenue.

Also produced was a report made by a commercial surveying company for the A.M.A. to determine why more advertising was not reaching the association's journals. The report was highly critical of delays encountered by producers while their advertising was making its slow way through the Council on Drugs. A promotion piece produced by the survey company noted that its report "helped" ease out the seal of acceptance program.

With this "evidence" on the record, Senator Kefauver made the direct charge that the A.M.A. was no longer a "free agent" and could not be trusted to take the prominent role it had projected for itself in informing and policing the industry.

Dr. Hussey and his supporting witnesses patiently and in detail answered the charges:

Instead of slackening off its efforts, the A.M.A. has consistently increased them in drug evaluation and all other scientific fields of medicine.

The publication referred to by Senator Kefauver was dropped only because it was not sufficiently broad in scope to serve a useful purpose.

Contrary to Senator Kefauver's opinion, the discontinued laboratories were not useful in testing of drugs.

The seal program was dropped for several reasons — it caused delay in getting useful drugs to the profession, it left the council too little time for its prime obligation of the consideration and early publication of information on drugs, it meant that the many valuable drugs not submitted to A.M.A. for advertising could not be carried in the association's annual publication on drugs.

A.M.A.'s advertising did not start its increase in 1955 but in 1951, before the seal was dropped. Furthermore, the rate of increase was about the rate of increase for advertising as a whole in this country.

Ads are screened more carefully now than ever before (by a committee that keeps in close contact with the council), and 85 per cent of those proposed are rejected.

The A.M.A.'s scientific activities never were subject to commerical pressures and the association "is now and always has been" independent of advertisers.

The association opposed a Kefauver bill requirement that complete information on a drug be carried in a bro-

chure inserted in every package. Dr. Hussey said it would be largely a waste of time because the druggist usually would throw away the brochure and the information wouldn't reach the physician.

Instead, the A.M.A. (whether the bill passes or not) is putting into effect its own program for informing physicians. Manufacturers will furnish the association with their pharmacologic, toxicologic and clinical data. These will be analyzed and the useful information published in J.A.M.A., which will also carry a new column, "New Drugs and Developments in Therapeutics." As another service, all available information on drugs will be combined into an extensive monograph to be included in "New and Non-Official Drugs." A further project will be annual publication of an "A.M.A. Handbook of Drugs," which will include information from J.A.M.A. and other sources.

In the forthcoming sessions, A.M.A. will be in the unfortunate position of having to sit back and hear Senator Kefauver and other subcommittee members repeat these charges again and again, asking witnesses to comment on them. The association's only defense will be to submit information which will go into the record — but probably not into headlines.

A.M.A. BITTERLY OPPOSES NEW DRUG BILL

The subcommittee's attacks against A.M.A. obscured, at least from the public, an important fundamental difference between Senator Kefauver and his staff and the doctors. The bill would have the Food and Drug Administration pass on the efficacy as well as the safety of drugs. A.M.A. bitterly opposes this, making these points:

1. Once the door was opened, F.D.A. shortly would decide to judge the *relative* efficacy of competing drugs, a responsibility that is not specifically spelled out in the language of the bill. In effect, the doctor witnesses said, government officials rather than practicing physicians would set drug standards for patients. A physician would hesitate to depart from F.D.A. regulations for fear of malpractice suits.

2. If F.D.A. decided a certain new drug was not sufficiently efficacious, that drug would never reach the market. Physicians and the public would be deprived of the benefit of information gained from the use of that drug by thousands of doctors on hundreds of thousands of patients. It was clear that Senator Kefauver and his staff are not aware that clinical testing is carried on by a relatively small number of particularly qualified physicians, and that all the values of a drug are not uncovered until after it has been prescribed on a widespread basis, usually for years.

Probably not by accident, opening of the Kefauver legislative hearings was preceded by publication of the subcommittee report on its investigation of the drug industry, which was strung out for most of last year. In the majority section of this document are paraded the accusations that have been Senator Kefauver's continuing thesis.

Prices are demonstrated to be too high by taking the raw material cost of a drug, adding a minimum processing charge, then comparing this low figure with the manufacturer's selling price. Another subcommittee technic to produce "evidence" of high prices is to quote foreign prices for the same product, often substantially lower for a number of reasons.

Senator Kefauver also claims the drug market is controlled by patents and prepatenting agreements and by refusal to license small manufacturers, all of whom presumably would produce the drug at a low price.

The minority (Republican) section of the report is such a contrast that it is difficult to realize both are based on the same set of hearings.

It calls the majority report "a monstrosity which was submitted to the minority for comment and analysis and appears to be nothing more than a calculated review of choice quips, statements and exhibits presented by biased witnesses whose views were well known to the majority at the time they were called to testify."

Then the Republicans (Everett Dirksen and Roman Hruska) go on to attack point by point all the majority conclusions, finding them "unfounded and erroneous."

A.H.A. IN AN AWKWARD SITUATION

American Hospital Association has found itself in a difficult situation, at least as far as public relations goes.

Largely through A.H.A.'s efforts, a Senate-House conference committee dropped from the social security bill a provision that would guarantee recipients of federal health care assistance the right to choose their own hospitals, physicians and druggists. The proposal came from Sen. Hubert Humphrey (D.-Minn.).

A.H.A.'s argument was that the provision would ensure the continued existence of below-standard nursing homes and, in general, below-standard medical care. However justified is A.H.A.'s position, the organization now is in the position of opposing free choice for relief recipients and low-income older people.

Although A.H.A. won the first round, the issue still isn't settled. Senator Humphrey and his supporters have various legislative devices that will allow them to raise the question again before the end of the session. They may not get the provision into the statute books, but they will be able to embarrass A.H.A. once more.

NOTES:

A.H.A.'s position on health care for the aged under social security continues a bit to the left of A.M.A.'s.

The hospital people don't condemn the Kennedy idea outright; instead they say this particular legislation is not the best that could be devised, that the social security approach eventually may be necessary, but that meanwhile every effort should be made to expand voluntary health insurance and strengthen the Kerr-Mills act, passed last year.

Although legislation to provide federal grants for constructing community health facilities has been reported favorably by a House committee, it is still a long way from enactment. It is opposed by some lawmakers (particularly Sen. Lister Hill) because it would operate outside the Hill-Burton controls.

A.H.A has won a victory in having housing for residents, interns and nurses included in the new housing act, but it so far has failed to make progress in its effort to obtain special grants for modernizing urban hospitals.

The Modern Hospital
AUGUST 1961

Michigan Study Ends With Bang

Hospitals Are Ineffectively Controlled — and Here's What To Do About It, Researchers Suggest

Aaron Cohodes

ANN ARBOR, MICH. — In matters of cost, quality and quantity of care, hospitals are ineffectively controlled, researchers at the University of Michigan report.

Winding up their $380,000 study* of health care in this state with a bang, the investigators fired criticism at every health care organization in sight. Moreover, they also produced some jolting recommendations for hospitals, administrators, boards of trustees, medical staffs, hospital associations, the Joint Commission on Accreditation of Hospitals, Michigan Hospital Service (Blue Cross), Michigan Medical Service (Blue Shield), the insurance industry, the state legislature, the Michigan State Medical Society, the state association of osteopathic physicians and surgeons, institutional licensing programs and boards, and the state insurance commissioner, whose failure to require the state Blue Shield plan to stick closely to the service principle may even, the researchers suggest, "result in a fraud upon the public to the extent that participating physicians are not readily available in all parts of the state."

The researchers found six interdependent factors (need, demand, motivation, standards, size and administration) that must be considered in developing effective controls. Trouble is, they suggest, most control patterns give uneven weight to these factors, or ignore some of them.

The researchers also noted that "cost, quantity and quality of care are inevitably intertwined, and any control pattern must adequately consider the reciprocal effects of each . . ."

Direct control of these factors, they assert, should be exercised by the providers of care "insofar as possible." Indirect control of these factors by other agencies, they emphasize, "must provide strong inducements of self-control, definitive standards, methods of monitoring performance and impartial enforcement."

The findings hit hard at weak methods for controlling the quantity of beds and services, pointing out that "relatively little has been accomplished to ensure that unnecessary duplication is kept to a minimum and that the addition of beds and services is brought about according to a rational, integrated plan designed to meet the needs of the state as a whole."

Here, the researchers suggest, is where district hospital councils, the state hospital association, and other voluntary agencies could be most helpful. This help, they noted, pointing an accusing finger at Blue Shield, the insurance industry and, to a lesser extent, Blue Cross, has not been forthcoming.

The warned that "if the voluntary third-party paying agencies do not sympathetically but firmly induce providers of care to control quantity (even though it is in their own interests to do so), then it may become necessary to influence quantity through legal controls."

The findings gave the investigators no reason to pin roses on the state insurance department, which they described as "woefully understaffed."

The department, they said, "is partly responsible for the failure of the financing agencies to exercise more influence in regard to the providers of care. Approving rates charged to subscribers of the hospital and medical service plans without attempting to influence the factors which determine rates can do more harm than good."

Methods for controlling the quality of hospital care have been unsuccessful, the researchers indicate, because (1) trustees seem to be reluctant to assert themselves in this area, (2) there have not been strong enough "external inducements" for the direct control of quality of care by doctors and hospitals, and (3) the medical profession has resisted new experiments and developments, a position the investigators describe as "not intelligent conservatism."

After devoting 43 pages to what is wrong with present methods of controlling cost, quantity and quality of care, the report suggested ways to improve these methods. Some of these recommendations are summarized on the next page.

*Reports of earlier findings from the study appeared this year in the June (p. 57) and July (p. 59 and p. 132) issues of The Modern Hospital.

Here Is How Researchers Recommend Michigan Hospitals Should Be Controlled

Hospitals, the report said, should:

– Develop and use all tools available for sound financial management.

– Create an internal organization that encourages direct control of all expenses in all departments.

– Establish medical staff committees to review cases routinely for appropriateness of admission, services and length of stay.

– Work with "appropriate agencies" utilizing the criteria for effectiveness developed as part of the study (The MODERN HOSPITAL, July 1961, p. 59).

– Participate in the program of the Commission on Professional and Hospital Activities.

– Select members of boards of trustees on the basis of their ability to understand the complexities of hospital operation, knowledge of management technics, and willingness to treat the hospital as a vital interest.

– Hire and train for full-time positions qualified personnel who will serve without the possibility of conflict of interests.

– Help resolve the conflict between M.D.'s and D.O.'s by offering their educational facilities to osteopaths.

Hospital boards of trustees, according to the findings, should:

– Specify the objective qualifications for membership in the medical staff, and specifically approve each staff appointment on the basis of medical staff recommendations.

– Work with the medical staff to develop objective criteria for use in delineating hospital privileges for physicians, and specifically approve the privileges granted to each physician on the basis of medical staff recommendations.

– Develop, with the assistance of the medical staff, by-laws and regulations that help control quality of care.

– Receive and analyze reports routinely on the functioning of all medical staff committees.

– Establish a joint conference committee, which should regularly evaluate the work of medical staff committees.

The Michigan Hospital Association, they said, should:

– Receive financial and statistical reports from the hospitals, compile comprehensive data, and provide interpretations of the data to individual hospitals, agencies which purchase care, and to research groups.

– Make (1) the existence of functioning review committees, (2) accreditation, (3) licensure and (4) uniform accounting procedures all conditions of membership within a reasonable time.

– Provide consultation services to help hospitals become accredited and to help them develop cost control mechanisms.

The Joint Commission on Accreditation of Hospitals, said the researchers, should:

– Work with the counseling program of the American Hospital Association on an experimental basis to develop standards covering hospital financial management.

– Use available hospital statistical data as a screening device to locate evidence of ineffective financial management.

– Broaden its inspection team to include a hospital administrator and an accountant.

– Place more emphasis on how hospital governing boards function in the area of control of quality of care.

Michigan Hospital Service (Blue Cross), they said, should:

– Try to merge with the state Blue Shield plan to provide hospital and medical benefits on a service basis.

– Develop a new reimbursement formula based on the accurate cost of covered services.

– Renegotiate contracts with hospitals regularly to permit greater flexibility under changing circumstances.

– Abolish as soon as possible the ceiling formula governing hospital reimbursements.

– Require all hospitals to create functioning review committees as a condition of participation.

– Select its board of trustees without consideration of the special interests that members might represent; thus, the only hospital representatives should be trustees whose selection was not based on their hospital connection.

Michigan Medical Service (Blue Shield), they said, should:

– Try to merge with Blue Cross.

– Increase the proportion of physicians who participate by, among other things: (1) requiring participating physicians to display a statement of their participation prominently in their offices, (2) making lists of participating physicians available to subscribers on request, (3) paying nonparticipating physicians substantially less than the amount paid to participating physicians, and (4) extending participating status to osteopaths.

The insurance industry, the researchers said, should:

– Require hospitals to submit annual audited cost reports.

– Specify that reimbursement for care will be made only in accredited hospitals in which there is a direct and reasonable relationship between costs and charges.

– Include pro rata clauses in contracts to prevent duplicate payments that exceed actual medical expenses.

– Pay only for services rendered by a doctor of medicine or osteopathy.

The state legislature, their report indicated, should:

– Provide that all public agencies reimburse hospitals at a rate not less than 100 per cent of the cost of services rendered.

– Create a new state agency and give it the authority to determine where and if new health care facilities should be built.

– Create a single licensing board for all health professions.

Finally, the state insurance commissioner, the report said, should:

– Establish higher standards that govern retention rates on health insurance contracts – and enforce them.

– Require Blue Cross to reimburse hospitals on a basis that is directly related to actual cost of services.

– Use his influence to stimulate all third-party paying agencies to exercise the control mechanisms suggested in this study. ■

Hospitals seem to pull their drug charges out of a hat instead of basing them on sound accounting methods, this study indicates

Why Hospital Drug Prices Baffle Patients

Robert S. Myers, M.D.

WITH increasing frequency one hears complaints from the public that hospitals are charging exorbitant prices for their services, and, of these, the chief targets seem to be the charges for drugs.

Apparently, there are two reasons for the public's clamor. In the first place, more and more patients are being informed of how much they are being charged for specific services. This is particularly so because of the widespread coverage by major medical insurance under which the patient receives an itemized bill for his hospital stay. If he is charged 25 cents for one aspirin tablet, the patient knows this precisely. Second, the patient also knows exactly the prices charged by the corner drugstore for such commonplace items as aspirin and sedatives, and he even has a fairly accurate estimate of the prices for the more exotic drugs, such as the antibiotics. Thus, he has standards of comparison for hospital charges. So, we have an informed and sophisticated public which believes it is being overcharged for drugs and is skeptical about the usual arguments advanced to justify hospital charges.

That the public has some justification for its complaints is shown from data collected through a 1959 survey of charges made for certain services by general hospitals in three midwestern states.

In this survey were 369 general hospitals, which represented 74 per cent of the general hospitals in the area. These hospitals were located in both rural and urban areas and ranged in size from six to 3200 beds. Of these 369 hospitals, 264 were voluntary nonprofit, 82 were governmental, and 23 were proprietary in their types of control.

Among the data collected in this survey were the charges made by each hospital for a single and equal dose of the following drugs:

Tetracycline – one 250 mg. capsule
Chloromycetin – one 250 mg. capsule
Terramycin – one 250 mg. capsule
Streptomycin – 1 gram
Penicillin-Crystalline – 500,000 units
Aspirin – one tablet
Phenobarbital – one tablet

In addition, the data revealed the individual hospital's basis for determining drug charges to the patient, that is, the percentage of markup added by the hospital to the cost of the drugs.

Table 1 shows the number and percentage of hospitals that listed a specific charge for each of the seven drugs, in addition to giving a definite percentage of markup. The response permits valid conclusions to be drawn.

Figure 1 presents the variations among hospitals in their charges for one 250 mg. capsule each of tetracycline, chloromycetin, or terramycin.

The hospitals are grouped according to their charges for these three antibiotics for, as a rule, the individual hospital made the same charge for a 250 mg. capsule of each of these drugs. It is apparent that there is a wide and significant variation between hospitals in the charges made for a single dose of an identical amount of these antibiotics. It is particularly difficult to imagine the justification for a charge from 70 cents to $1 per capsule as made by 9 per cent of these hospitals, when 50 per cent of those replying charged only 50 cents. This is especially so, when one considers that the cost to

Dr. Myers is executive assistant director of the American College of Surgeons.

FIG 1. CHARGES FOR TETRACYCLINE, CHLOROMYCETIN AND TERRAMYCIN

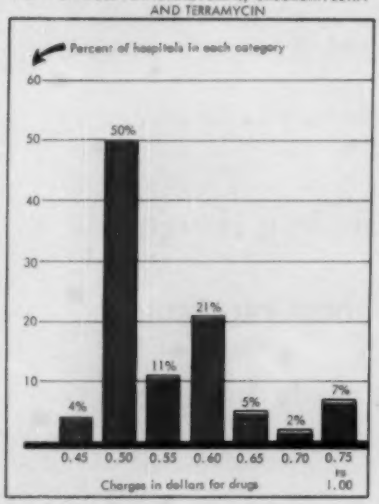


Fig. 1: Fifty per cent of hospitals reporting on charges for three antibiotics charge 50 cents per capsule.

FIG 2. CHARGES FOR STREPTOMYCIN

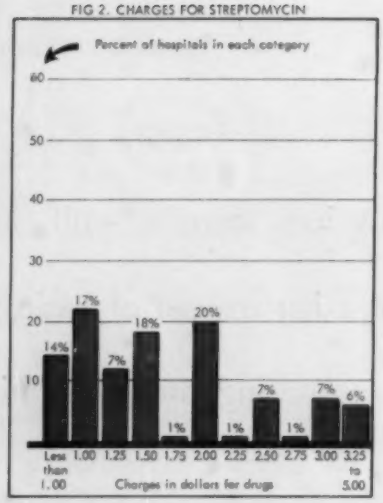


Fig. 2: One gram of streptomycin may cost patients less than $1 or as much as $5 in these 295 hospitals.

FIG 3. CHARGES FOR PENICILLIN-CRYSTALLINE

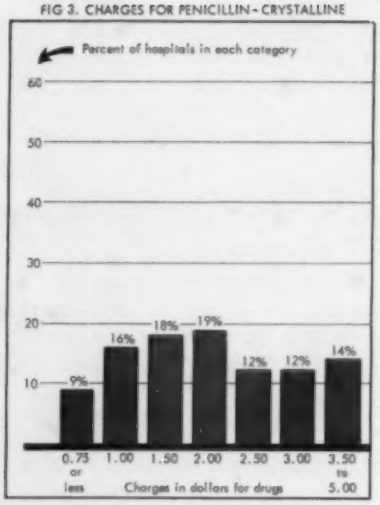


Fig. 3: Charges for 500,000 units of penicillin-crystalline vary widely in 284 hospitals answering question.

the hospital for a 250 mg. dose of one of these antibiotics approximated 30 cents, when bought in relatively small lots. What are the factors responsible for this 40 to 100 per cent difference in charges?

Figure 2 illustrates the variations between hospitals in their charges for one gram of streptomycin.

There is even less uniformity in charges for this drug than was apparent for charges for tetracycline, chloromycetin, or terramycin. Moreover, there are about as many hospitals (13 per cent) charging between $3 and $5 for a single dose of streptomycin as there are hospitals (14 per cent) charging less than $1 for the same amount. This is an extraordinary price differential, particularly when one realizes that one gram of streptomycin in solution cost the hospital approximately 35 cents. If the argument is advanced that the cost of the syringe and needle must be figured in the hospital's charge to the patient, then it must be pointed out that streptomycin is available commercially in a sterile injection kit with needle for less than 74 cents per dose, when purchased by the hospital in small lots.

In Figure 3, the charges for 500,000 units of penicillin-crystalline are presented.

It is obvious that there is a remarkably even distribution of hospitals in the various charge categories, which of themselves vary widely. This fact arouses the suspicion that there is no single, uniform and valid method of fixing charges among the hospitals in this survey. Which of the charge categories for penicillin-crystalline is valid and reasonable?

Figure 4 is of particular interest in that it shows a remarkable variation in the charges made by hospitals for a single aspirin tablet.

On the one hand, 36 per cent of the hospitals made no separate charge to the patient for this drug; on the other, 7 per cent levied upon every patient a flat rate of varying amounts for aspirin and other so-called floor drugs, such as sedatives and laxatives. Either of these two practices is understandable, but it is difficult to justify a specific charge for each aspirin tablet. It probably costs the hospital more to record the charge and to bill the patient than the fee collected for a single aspirin, unless the charge approximates 10 cents per tablet. But it is poor public relations to charge even 5 cents for one aspirin tablet, and it invites public wrath when the charge rises to 10 cents, to say nothing of 20 cents and more, as was done by 6 per cent of the hospitals replying. Hospitals should seriously consider adoption of a policy either of making no direct, individual charge for such stock items as aspirin or of levying an appropriate flat rate on all patients to cover such drugs.

From Figure 5, we see that hospi-

Table 1 — Number and Percentage of Hospitals Giving Information on Drugs — Total of 369 Hospitals.

	Tetracycline 250 mg. Cap.	Chloromycetin 250 mg. Cap.	Terramycin 250 mg. Cap.	Streptomycin 1 Gm.	Penicillin-Crystalline 500,000 U.	Aspirin 1 Tablet	Phenobarbital 1 Tablet	Markup
Number	273	305	303	295	284	133	125	248
Percentage	74%	83%	83%	80%	77%	36%	35%	67%

FIG. 4 CHARGES FOR ASPIRIN

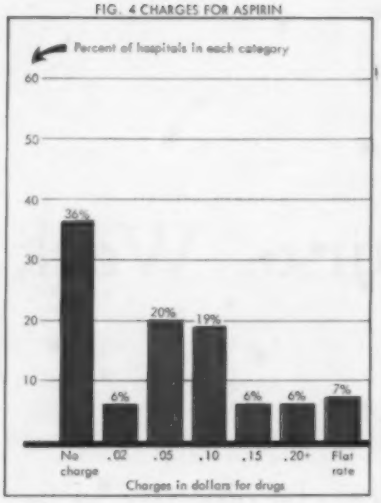


Fig. 4: Thirty-six per cent of 133 hospitals reported they make no separate charge to patients for aspirin.

FIG. 5 CHARGES FOR PHENOBARBITAL

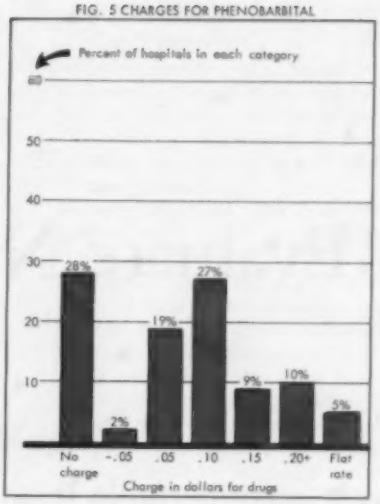


Fig. 5: Most hospitals reporting on this question (125) charge for phenobarbital; 28 per cent do not.

FIG 6. MARKUP

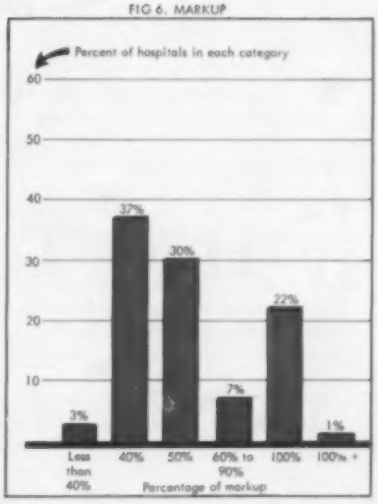


Fig. 6: Percentages of markup on drugs in 248 hospitals range from less than 40 per cent to 100 per cent.

tals have the same curious tendency to charge for each tablet of phenobarbital in spite of the fact that reason would prohibit this practice.

As with aspirin, the exact dosage of phenobarbital prescribed is not important. It is the principle that counts.

Figure 6 shows the percentages of markup that have been established by the hospitals to determine their drug charges.

In numerous instances, the percentages varied in the individual hospitals depending upon the costs of specific drugs. That is, there would be a 100 per cent markup on inexpensive drugs and 50 per cent markup on expensive items. In such instances, the lowest percentage was arbitrarily chosen in this study to represent that hospital's percentage of markup. This was done in an effort to represent as fairly as possible the markup policies of the hospitals and not to exaggerate these percentages. Be that as it may, there is still a wide range in markups between hospitals, although the majority (67 per cent) fall within the 40 to 50 per cent category.

The data from these 369 general hospitals were searched for evidence of the influence of type of ownership, size and location of the hospitals upon their charges for drugs, and it is of interest that there was no constant relationship between any of these factors and the charges made to the patient. Moreover, in cities with several or many hospitals there was little, if any, uniformity of charges between similar types of hospitals for an identical dose of the same drug. ■

High Cost of Drugs Complicates Hospital Finance

No one can decry the therapeutic value of the antibiotics and of the other modern drugs which have done so much to prevent and to cure disease. Certainly, their proper use has also reduced hospital stay and has thereby saved the patient money. But the very fact that these drugs are costly and that they are prescribed so frequently by the medical profession has complicated the financial practices of the hospital.

First, an adequate supply of these drugs must be on hand; and second, personnel and equipment must be constantly available for their administration to the patient. Such things cost money, and no one can challenge the premise that the hospital has the right to establish charges which reflect the full cost of providing its services, including those for drugs. Furthermore, it is recognized that the fixing of hospital costs and charges is most complex and is affected by many variables.

When one reviews the statistics from the accompanying survey of drug charges made by general hospitals, however, he cannot help wondering if the prevailing practices of hospitals in cost accounting and fixing charges are valid and realistic. Certainly, the impressions are gained either that some of the hospitals are not very businesslike in their financial affairs or that they are attempting to use their pharmacies to cover losses in other areas. Neither of these impressions is reassuring to the public.

Something should be done about this problem. If there are no adequate reasons for such wide variations in drug charges, better pricing procedures should be instituted generally. On the other hand, if these extreme variations are justified, the public should be so informed. In particular, someone should think up a good reason why hospitals should charge patients for an aspirin tablet.—R.S.M.

How To Evaluate Nurses' Work

This five-step guide to evaluating a nurse's work permits the evaluator to be objective in her appraisal – and keeps personalities out of it

Helen Malaspina, R.N.

HOW does a supervisor tell how well a graduate nurse is performing – without letting personalities and subjective impressions color her judgment?

At New York Polyclinic Medical School and Hospital, this is an especially important assignment as the hospital offers six months' courses in several nursing specialties to qualified R.N.'s. The clinical work of these students must be carefully rated.

After studying and modifying various appraisal methods available, we developed the evaluation procedures described in this article. These procedures have been used successfully for more than a year. They have been tested on 57 graduate nurse students.

We think they are effective. We also think that, with a minimum of refinement, they can be made to work effectively in other hospitals.

Here's how the procedures were put together.

As a first step, the following five criteria were carefully selected as being essential for competent professional practice: (1) appearance and personality, (2) work habits and job competency, (3) cooperation, (4) capacity for learning, and (5) initiative.

The second step in developing this method was to devise a technic which would eliminate personal opinion from any method that might be adopted and which would be simple to use.

Accordingly, we devised an evaluation guide, which we feel is self-explanatory (see opposite page). The evaluation guide is set up in abstract numbers from 4 to 0. The evaluator selects the abstract number which approximates her measure of the individual. The number is transferred to the evaluation form, beginning on page 71. A "comments" column is used to elaborate on statements in the guide with which the evaluator agrees or disagrees.

Because we were aware that qualifying adjectives do not mean the same to all people we made every effort to keep such subjective factors to a minimum. For example, we used descriptive phrases rather than words like good, fair and poor.

The director of nursing education generally selects the evaluators for the graduate nurse students. These are usually chosen from the ranks of nursing supervisors, the faculty, and

Miss Malaspina is director of nursing education, New York Polyclinic Medical School and Hospital, New York.

How To Use the Evaluation Form

The evaluator rates nurses on the basis of these guides, entering on the evaluation form the grade that comes closest to her estimate.

I. Appearance and Personality

A. GROOMING

4–Perfect grooming at all times.
3–Grooming neat. Observes safety precautions regarding clothing.
2–Neat. May forget to change shoes or may wear nylon slip occasionally.
1–Neglectful of appearance. Violates safety rules.
0–Shoes and uniform soiled. Disheveled. Poor personal hygiene. Ignores safety precautions.

B. EMOTIONAL MATURITY AND STABILITY

4–Emotionally controlled at all times. Recognizes own shortcomings. Assumes responsibility for own actions. Adaptable to moods of others.
3–Maintains emotional control in difficult situations. Sensitive, tries to adapt to moods of others. Usually accepts responsibility for own actions.
2–Good degree of emotional control in difficult situations. Usually sensitive, but not always adaptable to moods of others. Usually accepts responsibility for own actions. May make excuses.
1–Does well in routine situations. May be upset by new procedures. Influenced by moods of others. Usually finds excuses for own shortcomings.
0–Easily discouraged and upset. Impulsive. Inconsiderate. Moods changeable. Easily upset by temperamental people. Blames others for own faults.

C. RESPONSE TO CONSTRUCTIVE CRITICISM

4–Seeks and profits from constructive criticism. Appreciates correction.
3–Accepts and profits from constructive criticism.
2–Usually profits from constructive criticism. May feel it is undeserved.
1–Accepts but resents constructive criticism.
0–Rejects constructive criticism. Makes no attempt to correct errors. Defiant.

D. RELATION TO MEDICAL STAFF

4–Maintains appropriate relationships. Considerate, courteous, tactful.
3–Usually courteous, respectful, considerate and friendly but not familiar.
2–Knows how to maintain an appropriate relationship, but does not always apply this knowledge.
1–Too familiar. May take advantage of courtesy extended by medical staff.
0–Over-presumptuous, discourteous, uncooperative.

E. HEALTH

4–Excellent health. Never absent for illness. Works long hours at peak capacity.
3–Health very good. Rarely uses sick time. Works at peak capacity for major part of work period.
2–Health good. Uses sick time infrequently. Functions for 8 hour day.
1–Health fair. Tires easily.
0–Health poor. Always tired. Cannot handle average work load. Frequently absent because of miscellaneous complaints.

F. BASIC PERSONALITY

4–Even-tempered, poised, pleasant, loyal, trustworthy and well mannered.
3–Even-tempered, pleasant and well mannered in most situations.
2–Attempts to be poised, even-tempered, trustworthy and well mannered with fair success.
1–Usually polite and loyal. Unpleasant and evasive at times.
0–Cold, unpleasant, rude, disloyal, devious, argumentative.

II. Work Habits and Job Competency

A. PUNCTUALITY AND READINESS FOR WORK

4–Always on time and has necessary personal work equipment.
3–Never late without legitimate reason. Usually has necessary personal work equipment.
2–Occasionally late. Usually has necessary personal work equipment.
1–Frequently late. Forgets some necessary personal work equipment.
0–Always late. Unreliable. Forgets necessary personal work equipment.

B. ATTITUDE TOWARD EQUIPMENT AND SUPPLIES

4–Economical with supplies and careful with equipment. Conscious of cost.
3–Usually economical and careful with equipment and supplies.
2–Economical, but may waste supplies. Usually careful with equipment.
1–May abuse equipment and may waste supplies.
0–Careless of equipment, *i.e.* lets wheeled equipment bang against walls, forces instruments, etc. Wastes supplies. Not interested in cost or economy.

C. COMPLETION OF DAY'S WORK

4–Achieves work goals. Gives work progress report to nurse in charge before going off duty.
3–Usually attains work goals. Usually gives work progress report to nurse in charge before going off duty.

(Continued on Next Page)

others who are familiar with the clinical performance of the students.

As each evaluation form is completed, the nursing faculty transfers the grades to a composite evaluation form and the grades are averaged to form a combined grade. A combined grade of 4.0 is considered very superior; a combined grade of 3.0 is above average; a combined grade of 2.0 is average; a combined grade of from 1.0 to 0 is considered unsatisfactory. Students must achieve a combined grade of at least 2.0 to complete the course successfully.

In addition, the student is requested to fill in an evaluation form so that she may have an opportunity to measure her own abilities.

The composite evaluation form becomes a part of the student's permanent record. This form has become extremely useful in writing accurate letters of reference aimed at giving a valid description of clinical aptitude.

While we offer highly specialized programs, we feel our method emphasizes and measures the factors which we believe to be an integral part of the professional nurse, without regard to the area of specialization in which she functions. ■

2–Tries to accomplish goals. Notifies nurse in charge before going off duty.
1–Tasks may or may not be completed. May neglect to report unfinished work to nurse in charge before going off duty.
0–Makes no attempt to complete assignments. Does not report when going off duty.

D. CONSIDERATION FOR PATIENT

4–Sympathetic, courteous, tactful. Makes time to greet patient pleasantly. Respects patient confidences. Considers patient's comfort.
3–Usually makes time to greet patient pleasantly. Usually sympathetic, courteous, polite. Tries to make patient comfortable. Rarely gossips about patients in public areas. Avoids unnecessary exposure of patient.
2–Tries to greet patient pleasantly and make him comfortable. Occasionally gossips about patients in public areas. Tries not to expose patient and tries to be sympathetic, courteous and tactful.
1–Usually too busy to greet patient properly. May be discourteous, tactless or unsympathetic. May be indifferent to patient exposure. May violate patient confidences.
0–Inconsiderate of patient's comfort and safety. Regards patient as "just another case." Exposes patient unnecessarily. Gossips about patients.

E. QUALITY OF WORK

4–Plans and organizes work with maximum economy of time and effort. Executes plans effectively with appropriate attention to details.
3–Work is well planned and organized with economy of time and effort. Plans carried to completion with attention to details.
2–Work adequately planned and well organized. Executes assignments in moderate amount of time with attention to details.
1–Work inadequately planned and disorganized. Overlooks details, or may become immersed in details. (Specify which.)
0–Work poorly planned and disorganized. Clumsy, careless, slow and inept.

III. Cooperation

Consideration for patients and ability to cooperate are important attributes

A. ATTITUDE TOWARD CO-WORKERS

4–Works very well with others and is willing to help. Volunteers services freely. Enjoys being part of group. Respects rights of others. Gets along very well with auxiliary personnel.
3–Works well with others. Willing to help. Usually volunteers services. Participates in group activities. Gets along well with auxiliary personnel. Usually respects rights of others.
2–Usually works well with others. Usually willing to help. May volunteer services if needed. Tries to take part in group activities. Tries to respect rights of others. Usually gets along with auxiliary personnel.
1–Rarely works with others. Usually unwilling to help. May take part in group activities. May dominate auxiliary personnel.
0–Prefers to work alone. Refuses to help others. Avoids group activities. Treats auxiliary personnel as menials and inferiors.

B. ATTITUDE TOWARD SUPERVISORY PERSONNEL

4–Respectful. Friendly without being familiar. Courteous, polite and cooperative at all times. Always feels able to discuss problems with supervisory personnel.
3–Respectful, courteous, polite, and cooperative most of the time. Feels able to discuss problems with supervisory personnel.
2–Usually tries to be courteous, respectful, polite and cooperative. May hesitate to discuss problems with supervisory personnel.
1–May be discourteous, disrespectful, impolite and uncooperative. Unwilling to discuss problems with supervisory personnel.
0–Rude, rebellious and ill mannered, or fawning, obsequious and ingratiating. Refuses to discuss problems with supervisory personnel.

C. CHANNELING OF COMMUNICATIONS

4–Recognizes need for orderly communication through established channels. Notifies nurse in charge of pertinent matters at first opportunity (examples – faulty equipment, accidents, missing supplies, changes in patient's condition, broken needles, breaks in technic).
3–Observes established channels of communication. Usually notifies nurse in charge of pertinent matters at first opportunity. (See examples above.)
2–Usually observes proper channeling. May neglect to notify nurse in charge of problems and activities of the department.
1–If she can handle the situation, does not bother to notify nurse in charge.
0–Feels it unnecessary to notify nurse in charge of pertinent matters.

D. INTERDEPARTMENTAL RELATIONSHIPS

4–Always tactful and courteous in interdepartmental relationships. Aware of need for harmonious relationships for proper functioning of all departments.

3–Usually aware of need for harmonious relationships with all departments and is usually courteous and tactful in dealings.

2–Aware of need for harmonious relationships with all departments but occasionally may not be courteous or tactful in dealings.

1–May be aware of need for harmonious relationships, but feels effort should originate from other departments. Makes no effort to be courteous or tactful.

0–Feels that other departments exist only to serve her.

E. ATTITUDE TOWARD POLICY CHANGES

4–Accepts, understands and complies with policy changes.

3–Accepts and complies with policy changes although cannot see immediate need.

2–Accepts and usually complies with policy changes, but may question need.

1–Rarely accepts policy changes without argument. Cannot be trusted to comply.

0–Resents policy changes. Will not comply if inconvenient.

IV. Capacity for Learning

A. UNDERSTANDING AND APPLICATION OF BASIC PRINCIPLES OF NURSING

4–Excellent understanding and application of basic principles of nursing. Strives to increase her knowledge and improve her patient service.

3–Has good understanding and application of basic principles of nursing. Usually strives to increase her knowledge and improve her patient service.

2–Has an adequate understanding of basic principles of nursing and usually applies it. Takes advantages of opportunities to increase her knowledge and improve her technics, if convenient.

1–May have a good understanding of basic principles of nursing, but there is little application. Usually uninterested in increasing knowledge or improving patient service.

0–Basic knowledge of principles of nursing is deficient. Makes no effort to improve.

B. RETENTION AND APPLICATION OF INSTRUCTION

4–Follows all procedures as taught without prompting or review.

3–Usually follows procedures as taught. Needs little review.

2–Follows most procedures as taught, but may need some review.

1–Tries to follow procedures as taught, but may forget or misinterpret instruction.

0–Carries out procedures to suit herself. Inconsistent.

C. ADAPTABILITY TO NEW PROCEDURES

4–Grasps fundamentals. Adapts to new procedures quickly.

3–Usually grasps fundamentals. Adapts to new procedures quickly.

2–Adapts gradually to new procedures. May need some review.

1–Needs lengthy, detailed explanations, demonstrations and practice before adapting to new procedures.

0–Cannot adapt to new procedures regardless of detailed explanations, repeated demonstrations, and practice.

V. Initiative

A. ADAPTABILITY AND JUDGMENT

4–Perceptive. Adapts basic technics to meet the needs of any situation. Uses good judgment when confronted with work emergencies.

3–Adapts basic technics to meet the needs of most situations. Usually uses good judgment and rarely needs help in emergency situations.

2–Adequate judgment for routine situations. Seeks help occasionally to meet emergency situations.

1–Seldom uses own judgment. Consults nurse in charge on minor problems. Little ability to cope with emergencies.

0–Judgment poor. Prefers to let others solve work problems. Cannot cope with emergencies.

B. INDEPENDENT ACTIVITY

4–Uses time constructively when not assigned.

3–Usually uses time constructively when not assigned.

(Continued on Next Page)

Clara M. Found (left), graduate nurse, discusses the evaluation of her clinical performance with Rita J. Foote, a head nurse at hospital.

(Continued From Preceding Page)

2–Knows how to use time constructively when not assigned. Does not always do so.
1–Usually needs to be told what to do when not assigned.
0–Waits to be told what to do, and then procrastinates.

C. RECOGNITION AND CORRECTION PROBLEMS

4–Anticipates problems arising from schedule deviations and notifies nurse in charge. Anticipates and meets needs of her unit or patient.
3–Usually anticipates problems arising from schedule deviations and notifies nurse in charge. Usually anticipates and meets needs of her unit or patient.
2–Tries to anticipate problems arising from schedule deviations. May or may not notify nurse in charge. Tries to anticipate and meet needs of her unit or patient.
1–Rarely anticipates problems. Does not anticipate needs of her unit.
0–Does not recognize problem areas. Cannot meet needs of her unit or patient.

THIS FORM IS USED TO EVALUATE STUDENTS

STUDENT Mary Smith DATE March 23, 1961

AREA OF EVALUATION	GRADE	COMMENTS
I. APPEARANCE AND PERSONALITY		
A. Grooming	3	
B. Emotional maturity and stability	2	Sometimes inclined to procrastination.
C. Response to constructive criticism	4	
D. Relation to medical staff	2	
E. Health	4	
F. Basic personality	2	
II. WORK HABITS AND JOB COMPETENCY		
A. Punctuality and readiness for work	4	
B. Attitude toward equipment and supplies	4	
C. Completion of day's work	4	
D. Consideration for patient	3	
E. Quality of work	2	
III. COOPERATION		
A. Attitude toward co-workers	4	
B. Attitude toward supervisory personnel	3	
C. Channeling of communications	3	
D. Interdepartmental relationships	3	
E. Attitude toward policy change	4	
IV. CAPACITY FOR LEARNING		
A. Understanding and application of basic principles of nursing	2	
B. Retention and application of instruction	2	
C. Adaptability to new procedures	2	
V. INITIATIVE		Eager to apply new ideas in the clinical situation.
A. Adaptability and judgment	3	
B. Independent activity	3	
C. Recognition and correction of problems	4	

ADDITIONAL COMMENTS:

This student has been above average in performance in many aspects. Her understanding of basic nursing principles needs to be strengthened.

Evaluation by: Jane Doe, Supervisor

The comments column in this evaluation form can be used by the evaluator to elaborate on statements with which she agrees or to note exceptions to any statement in the guide with which she disagrees.

Three-story circular nursing unit of St. Frances Xavier Cabrini Hospital, Montreal, will grow to six stories.

Plan Turns Travel Time to Nursing Time

Comparison of four types of nursing unit led planners to select the circle as being best designed to save footage and nurses' footwork

HOSPITAL officials, planners and patients of St. Frances Xavier Cabrini Memorial Hospital in Montreal have nine good reasons to be pleased with their new 173 bed hospital, according to Dr. Gerald LaSalle, the hospital consultant. The hospital, described on the next three pages, features a circular nursing unit.

The circular design was selected by the architects, De Sina & Pellegrino, New York, after study of several typical schemes for a 50 bed nursing unit because it offered the greatest efficiency and economy of both nursing time and equipment, they explain.

The advantages cited by Dr. LaSalle are:

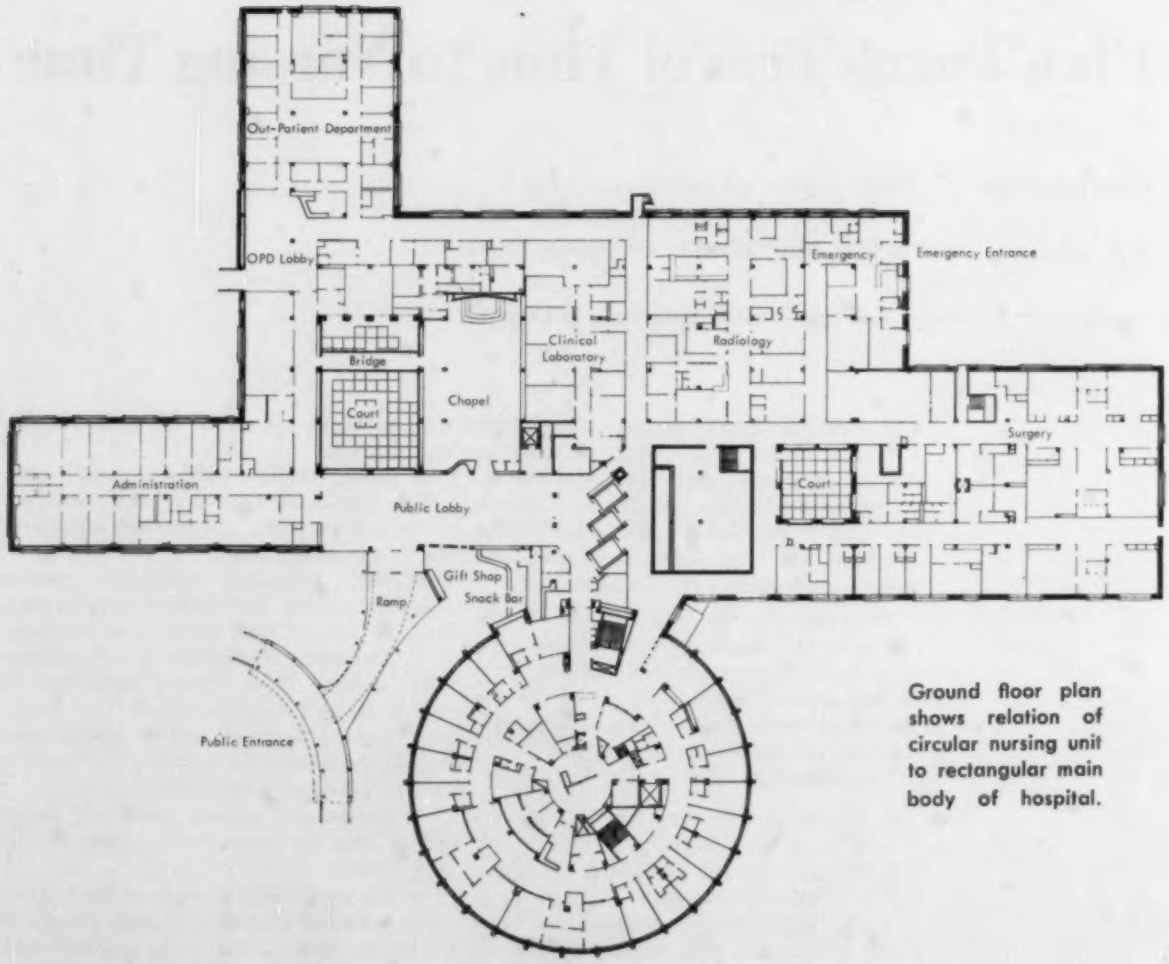
1. Shorter distance from the nursing stations to the patients' rooms.
2. Intensive therapy wards with visual control from the adjoining nurses' station.
3. One large utility room equidistant to all rooms and to the two nursing stations adjoining the intensive therapy ward and the service elevator.
4. Excellent control of all traffic to the patient areas.
5. Service elevator within the utility area, which eliminates cross-circulation with patients and the public and provides rapid service to the nursing floors.
6. Well integrated emergency service wherein radiology and fracture room facilities and the surgical suite are in close proximity.
7. Expansion possibilities of all facilities and services. Three nursing floors can be added by vertical expansion in the circular unit, and the diagnostic and therapeutic services in the rectangular section of the building can be expanded horizontally.
8. Interior and exterior connecting recreational areas for the pediatrics department at grade level.
9. Air conditioning throughout the hospital, with individual controls in nursing areas, electronic air cleaners, and special germicidal air washers in operating rooms and nurseries.

(*Continued on Next Page*)

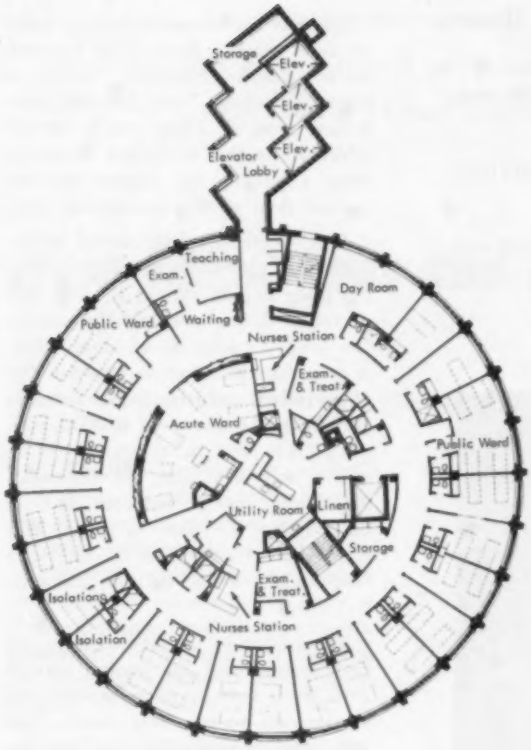
The Hospital Will Grow Up as Well as Sideways

The 173 bed section of St. Frances Xavier Cabrini Hospital, which was opened in September 1960, is the first of three phases of construction.

Ultimately, the hospital will reach a capacity of 658 beds when a second circular unit is built. More immediate plans call for the addition of 156 beds with the addition of three floors to the present circular nursing unit. The architects point out that the existing physical plant, including therapeutic, diagnostic, laundry, mechanical plant, maintenance and service facilities, has been designed to accommodate the additional beds. These ancillary services, outpatient clinic, and emergency unit are housed in the rectangular section of the hospital.



Ground floor plan shows relation of circular nursing unit to rectangular main body of hospital.



Central utility room on each patient floor serves both stations.

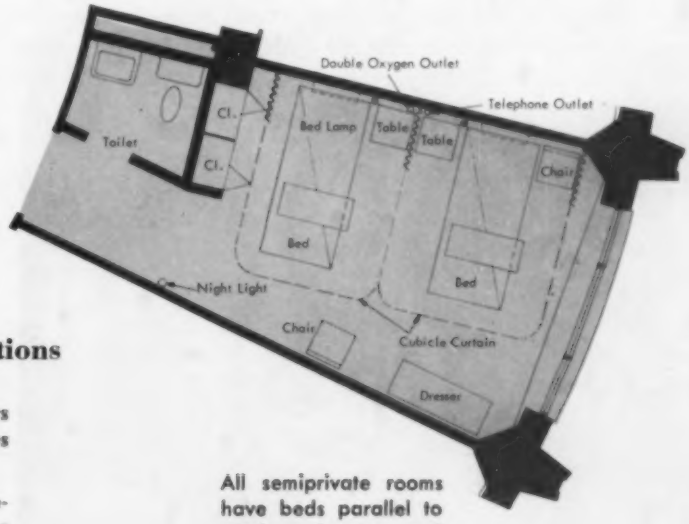
OUTLINE OF CONSTRUCTION COSTS
(St. Frances Xavier Cabrini Hospital, Montreal)

Total project cost		**$4,500,000.00**
No. of beds	**173***	
(planned for 156 additional)		
Cost per bed**		**24,200.00**
Total square feet	**170,800**	
Square feet per bed	**918**	
Cost per square foot		**26.35**
Total cubic feet	**2,104,000**	
Cubic feet per bed	**11,312**	
Cost per cubic foot		**2.14**

*In addition to the adult beds, the hospital has 40 bassinets, which, on the assumption that 1 bassinet equals 1/3 of a patient bed, brings the total to 186.

**The architects point out that the existing physical plant has been designed for the ultimate bed capacity of 329 beds plus 40 bassinets.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made each month.



All semiprivate rooms have beds parallel to windows; lavatory and toilet adjacent to nursing service corridor.

Utility Room Serves Two Stations

The entire perimeter of the patient floors is devoted to patient use, with all services located in a central core.

This arrangement, the architects say, requires only 10 lineal feet of exterior wall per bed in contrast to 14.5 lineal feet necessary with a rectangular single corridor plan. It also reduces the distance nurses must travel from the central utility area to the patient's bed to 50 feet as against 96 feet in the rectangular plan. Thus, it is pointed out, nurses can perform their tasks more efficiently because the "walking time" saved can be converted to nursing time. Two centrally located nurses' stations on each patient floor afford flexibility in staffing. (*Continued on Next Page*)

Two nursing stations on each floor and circular corridor with four-way access to central utility service area provide visual control of patients and visitors

One of the two nursing stations located in the central core of each patient floor. They are separated by the utility area.

Acutely ill patients are cared for in six-bed intensive therapy unit, which also serves as miniature postoperative recovery room.

(*Continued From Page 77*)

There is one intensive therapy ward on each nursing floor of St. Frances Xavier Cabrini Hospital, "which is where it belongs," the hospital consultant reports. These wards are in addition to the seven-bed recovery room adjoining the surgery on the ground floor of the rectangular unit.

Each acute ward is located in the center of the floor, separated from the main nurses' station by a glazed partition through which the nurses can keep it under direct observation. A pass-through window between the acute ward and the nurses' station permits the delivery of needed supplies from the dumb-waiter.

The second station, on the opposite side of the central core, is used only during the day. At night, it is controlled by the nurse on duty who can reach it easily through the central utility core.

In addition to the six-bed intensive care section and the central service core, each floor contains private and semiprivate rooms, two wards, and two isolation rooms for patients; two examining and treatment rooms in the center section, and a teaching room, dayroom, and a third examining room located on the periphery of the building.

A ground floor location was selected for the obstetrics and pediatrics departments. A patio adjoins the pediatric playroom so that the children may have outdoor recreation when the weather is suitable. Placement of maternity and nursery at ground level, the architects explain, helps relieve the elevators of a large amount of visitor traffic, and the proximity of the obstetrics department to the maternity nursing unit makes it possible to move patients rapidly to the delivery suite. ■

Dayroom on the obstetrical floor has pantry where patients make snacks.

Census lulls during week ends and holiday periods lower over-all occupancy rate by only a few percentage points, this study of 14 Pennsylvania hospitals indicates

How Week Ends and Holidays Affect Occupancy

Morris London and Robert M. Sigmond

ALTHOUGH week ends and holidays are low points in hospital census, their total effect on occupancy is not as great as has been assumed.

The decline during these periods reduces total occupancy by only a few percentage points, according to preliminary data from the hospital bed occupancy study of the Hospital Council of Western Pennsylvania.

During the four months, November through February, a period which includes the major holidays affecting census, the over-all occupancy rate for the 14 hospitals in the study was 83. Excluding week ends and holiday periods, the over-all occupancy rate was 87, or only four percentage points higher. The study showed that factors other than week-end and holiday patterns, such as excessive beds in relation to demand and inflexibility in the use of beds, are major causes of low over-all occupancy.

Since there is no evidence that serious illness regularly declines over week ends and holidays, why should there be any decline in hospital census during these periods?

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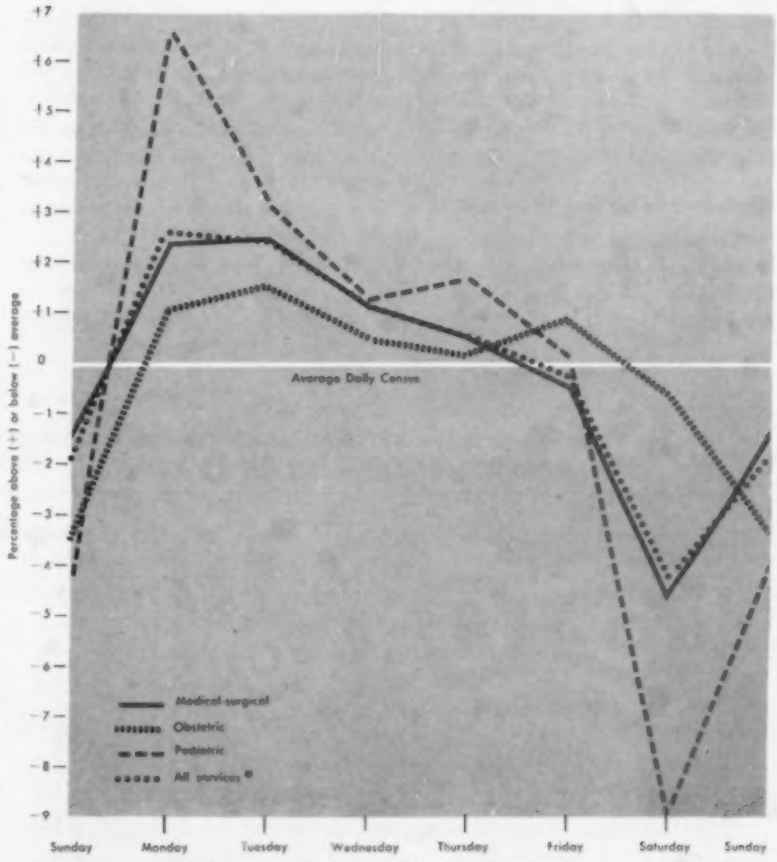


*Includes an average daily census of 56 in specialized segregated psychiatric facilities maintained by three of the study hospitals.

Graph 1, of fluctuations of average census by day of week (Nov. 1, 1959-Feb. 29, 1960) shows peak on Monday or Tuesday with a Saturday low.

Morris London is assistant director, Jefferson Medical College Hospital, Philadelphia. Robert M. Sigmond is executive director of the Hospital Council of Western Pennsylvania. When the article was written, Mr. London was research associate of the Hospital Council of Western Pennsylvania.

This is the third and concluding article which presents preliminary findings and tentative conclusions from the hospital bed occupancy study being conducted by the Hospital Council of Western Pennsylvania under a Hospital and Medical Facilities Research Grant from the U.S. Public Health Service (Project W-141).

Census statistics furnished by 14 general hospitals, together with a review of their administrative practices, provide the basic information in this two-year study.

The first article pointed out that high occupancy hospitals are more successful in controlling variations in demand for inpatient service (Are We Building Too Many Hospital Beds? *p.* 59, January 1961).

The second article showed that small independent bed units generally have relatively high variability in daily census, which, in turn, is reflected in relatively low occupancy rates (Small Independent Bed Units Lower Hospital Occupancy, *p.* 95, May 1961).

This final article analyzes the extent of census declines over week ends and holiday periods. As in the preceding articles, the census data discussed cover the first four months of the study.

STABILIZE DAILY CENSUS BY SCHEDULING 'ELECTIVE'

(*Continued From Preceding Page*)

Consistent week-end and holiday census patterns clearly demonstrate that factors other than medical need influence utilization of hospital services. Personal considerations of patients and their families, established work patterns of physicians, and various hospital routines have a definite effect on the timing of hospital admissions and discharges. Accordingly, hospital officials need not hesitate to encourage more even scheduling of elective admissions in order to stabilize daily census and thereby improve the quality and efficiency of service.

Fluctuations by Day of Week

The peak census day was reached on Mondays and Tuesdays, when census was 2 to 3 per cent above the average (see Graph 1). Average daily census declined slightly Wednesdays through Fridays and reached the lowest level on Saturdays, when it was about 4 per cent below the average. Census rose again on Sunday owing to the large number of admissions which characteristically occurred on that day, but it was still below the average for the week as heavy week-end discharges continued. The over-all deviation range — from the peak census at 2.5 per cent above average on Monday to 4.3 per cent below average on Saturday — was 6.8 per cent.

Thirteen of the 14 hospitals in the study had their peak census day on either Monday or Tuesday. Saturday was the low-point in census for 12 of the 14 hospitals (see Table 1).

Of the seven hospitals with the lowest occupancy (80 per cent or less), all but one had a deviation range between peak and low census *in excess of 7 per cent*. Of the seven hospitals with the highest occupancy rates (above 80 per cent), all but one had a deviation range *of less than 7 per cent* (see Table 1). These data indicate that fluctuations by day of the week are subject to partial control.

Over-all occupancy was 80 per cent on week ends compared with 84 per cent on week days. If all week ends were eliminated, over-all occupancy would have been increased just 1 per cent — from 83 to 84 per cent (see Table 2).

Among individual hospitals, the widest difference between week-day and week-end occupancy was five percentage points. The seven low occupancy hospitals as a group had a slightly greater difference between

TABLE 1 — HOW AVERAGE DAILY CENSUS FLUCTUATES BY DAY OF WEEK IN 14 VOLUNTARY GENERAL HOSPITALS, NOV. 1, 1959, TO FEB. 29, 1960

	Hospital Code	Number of Beds	Occupancy	Average Daily Census	Percentage Above or Below Average Daily Census							Deviation Range
					Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	
Low Occupancy	A	244	74	180	−2.3	3.5	2.1	0.7	0	1.8	−5.6	9.1
	B	198	75	148	0.7	2.8	0.7	1.6	1.3	−2.2	−5.0	7.8
	C	329	76	252	−2.2	3.2	2.3	0.9	0.9	1.1	−6.4	9.6
	D	264	79	207	−1.5	1.8	1.5	1.5	0.6	0.3	−4.3	6.1
	E	337	79	267	−4.1	2.8	3.6	2.0	0.5	0.1	−4.7	8.3
	F	216	80	174	−3.4	4.8	2.8	0.6	0.6	0.2	−5.9	10.7
	G	350	80	281	−1.9	3.0	3.8	2.6	0.7	−2.4	−5.8	9.6
High Occupancy	H	225	82	184	−3.0	1.9	1.7	1.1	2.5	−0.2	−4.0	6.5
	I	383	86	328	−2.6	1.8	2.8	2.1	2.0	0	−5.9	8.7
	J	380	86	328	−0.3	2.2	2.2	0.4	0.3	−0.5	−4.6	6.8
	K	278	88	244	−1.3	3.0	2.1	0.9	−0.3	−1.4	−3.2	6.2
	L	313	89	280	−2.6	1.3	2.6	0.7	−0.1	0.1	−2.0	5.2
	M	312	91	282	−0.8	1.7	1.9	−1.1	−1.0	−0.3	−0.5	3.0
	N	164	91	150	−1.9	2.1	1.6	0.5	−0.1	0.4	−2.8	4.9
	Total Group	3993	83	3305	−1.9	2.5	2.4	1.1	0.5	−0.2	−4.3	6.8

Table 1 compares fluctuations of average census by day of week for the high and low occupancy hospitals, with the seven low occupancy hospitals (below 80 per cent) showing greatest deviation between peak and low days.

ADMISSIONS EVENLY

week-end and week-day occupancy than the seven high occupancy hospitals (see Table 2). These differences are not substantial enough in themselves to account for the relatively low occupancies of these hospitals.

Fluctuations by Service

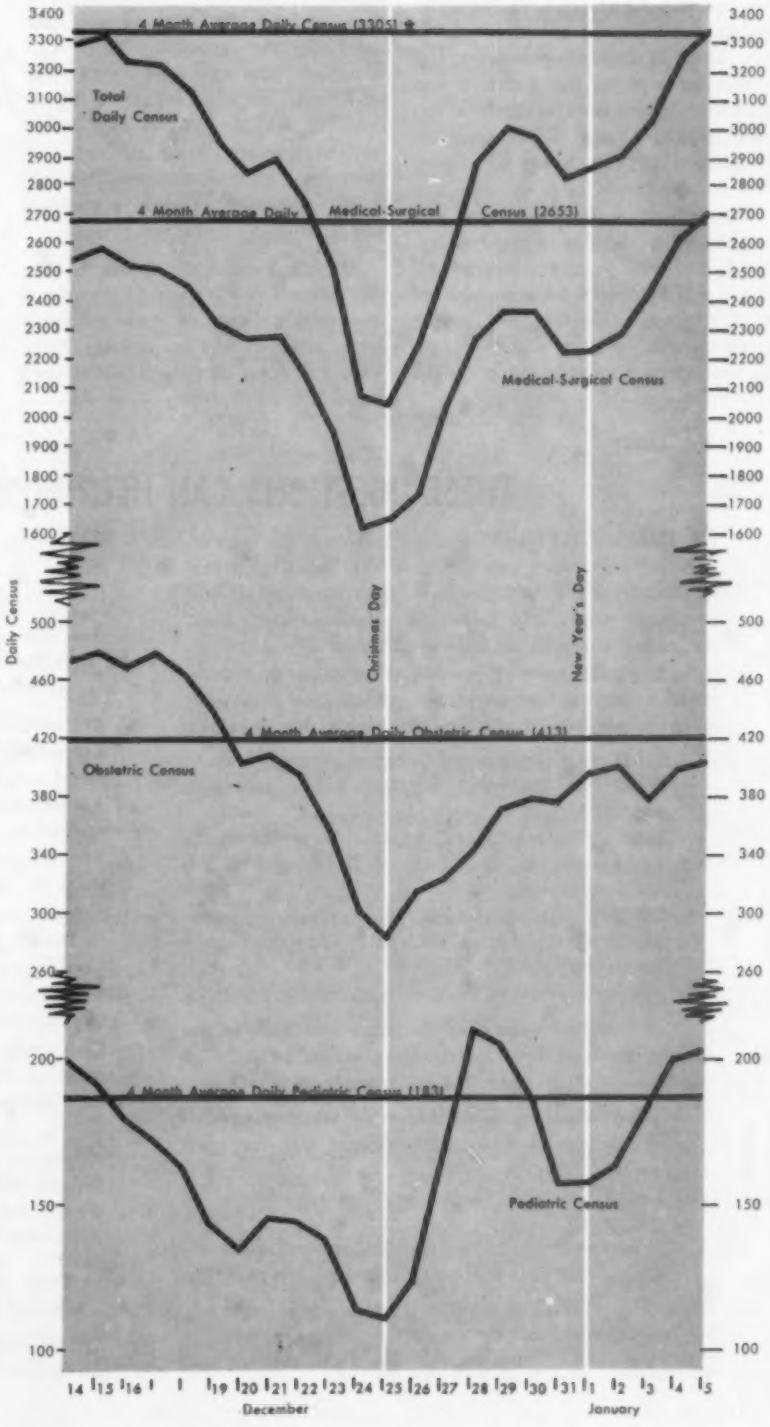
The fluctuation of medical-surgical census by day of week was almost identical with the over-all pattern. Pediatric census had the widest fluctuation by day of week, declining from almost 7 per cent above average on Mondays to 9 per cent below average on Saturdays, a deviation range of 16 per cent. The low point in medical-surgical and pediatric census on Saturday reflected a marked decrease in elective admissions and a sharp rise in the number of discharges.

Maternity had the narrowest range of census fluctuation by day of week. This finding presumably results from the fact that admission dates to maternity (except for inductions and cesareans) are determined by medical need. Discharges from maternity were heaviest on Sunday when maternity census was almost 4 per cent below average. The low maternity census on Sunday appears to reflect a variety of social and economic as well as professional considerations.

Apparently, hospitals have elective discharges as well as elective admissions.

Occupancy Slump at Holidays

Three holidays occurred during the 121 day period for which census statistics were tabulated – Thanksgiving, Christmas and New Year's. Compared



Graph 2 shows the decline in census in the 14 hospitals between Dec. 14, 1959, and Jan. 5, 1960, during which the census was consistently below the hospitals' average census.

Asterisk on table indicates average daily census of 56 in specialized segregated psychiatric facilities maintained by three of the study hospitals. Average census data therefore do not total.

with the average census for nonholidays of the same day of the week, Thanksgiving Day census was 15 per cent below normal; Christmas Day census was 40 per cent below normal, and New Year's Day census was 18 per cent below normal.

The effect of each of the holidays was greater in the medical-surgical and pediatric services than in maternity. Even in maternity, however, the census on each of the holidays was markedly lower than normal: a decline of 17, 33 and 7 per cent for Thanksgiving, Christmas and New Year's respectively.

The holiday decline in census was not limited to the day of the holiday, but began one or more days in advance and continued for a number of days afterward. During the Thanksgiving period, census was depressed an average of six days among the 14 study hospitals. During the Christmas to New Year period, the hospitals operated continuously at below average census levels for 22 days, from December 14 to January 5 (see Graph 2).

The 14 hospitals operated at an over-all occupancy rate of 73 per cent during the 28 calendar days during which census appeared to be depressed by the effect of the holidays. For the remaining 93 days of the study, the hospitals operated at an over-all occupancy rate of 86 per cent. If the 28 day holiday period were completely eliminated from consideration, over-all occupancy would have increased three percentage points, from 83 to 86 per cent.

The depressant effect which holiday periods had on census was much less among hospitals with relatively high occupancy than among those with relatively low occupancy. Not only was the proportionate decline in census smaller, but there were fewer days during which occupancy was depressed.

In the three hospitals with the lowest over-all occupancy rates (74 to 76 per cent), the Christmas to New Year holiday effect lasted from 24 to 30 days, whereas in the three hospitals with the highest over-all occupancy rates (89 to 91 per cent), it lasted from 14 to 18 days. Census on Christmas Day averaged 48 per cent below normal in the three low occupancy hospitals compared with 31 per cent below normal in the three high occupancy hospitals. There is every indication that the marked holiday lull in the low occupancy hospitals is not a basic cause of their low occupancy.

Declines in census during holiday periods were much greater than the

THESE QUESTIONS CAN HELP HOSPITALS INTERPRET THEIR

ADMINISTRATORS who are interested in increasing occupancy can derive several areas for investigation from the tentative findings of the hospital bed occupancy study. The following questions offer a basis for such a study by an individual hospital.

1. With the existing pattern of variation in census, could a nursing unit be closed without any inconvenience to patients or doctors? Last year, for example:

- What was the over-all constant vacancy rate?*
- What was the constant vacancy rate for each service?
- Was the number of constantly vacant beds on any specific service as large as, or larger than, the smallest nursing unit?
- Do any constantly vacant beds result from administrative practices, such as holding beds open for emergencies?
- Are such practices justified by actual experience?

2. Is there evidence that the number of beds in use can be reduced by administrative action to stabilize variation in daily census? Last year, for example:

- What was the over-all variable vacancy rate?
- What was the variable vacancy rate for each service?
- Did the over-all variable vacancy rate exceed 10 per cent?
- What was the highest medical-surgical census?
- On how many different calendar days did the peak occur?
- What were the second and third highest census days?
- How frequently were these peaks attained?

3. Are there too many different classifications of beds, with the result that waiting patients sometimes are not admitted although some beds are empty?

- Are certain beds reserved for specific physicians?
- Are certain beds reserved for patients of certain racial origins?
- Are certain beds reserved for patients with diseases in various medical or surgical specialties?
- Are surgical patients ever admitted to medical units or vice versa?
- Are certain nursing units reserved for either male or female patients?
- Could remodeling to provide additional toilet facilities eliminate the need for this type of bed classification?
- Are semiprivate patients ever admitted to ward areas or vice versa?
- Are children admitted to general nursing units?
- Is the age limit in pediatrics flexible, varying somewhat in relation to demand?
- Would physical alterations make it possible to set up "accordion" type units in pediatrics and maternity?

4. Is there evidence that the classification of beds is not adjusted properly to existing demand for beds?

- Would reshuffling of nursing units result in need for fewer beds?

*Definition of terms can be found in "Are We Building Too Many Hospital Beds?" Mod. Hosp. 96:59 (January) 1961.

declines over week ends and had a greater effect on over-all occupancy.

Our study of the factors which affect hospital occupancy indicates that a number of elements contributed to these week-end and holiday lulls, such as the unwillingness of patients to enter or remain in hospitals, reduced hospital staffing, and unavailability of some attending physicians. The relative importance of these and other factors has not yet been investigated. In any event, it appears that week-end and holiday lulls are not a major contributory factor to low occupancy. ■

Table 2 indicates that week ends accounted for only 1 percentage point difference in occupancy for both the high and low occupancy hospitals and for the whole group.

TABLE 2 — COMPARISON OF HIGH AND LOW OCCUPANCY SERVICES ACCORDING TO WEEK DAYS AND WEEK ENDS

Service	Percentage of Occupancy			
	Total	Week Day	Week End	Difference
Medical-Surgical				
7 High Occupancy Services	92	93	90	3
7 Low Occupancy Services	82	84	79	5
Total	88	89	85	4
Obstetric				
6 High Occupancy Services	79	80	78	2
7 Low Occupancy Services	56	57	55	2
Total	69	70	68	2
Pediatric				
5 High Occupancy Services	70	71	66	5
6 Low Occupancy Services	54	56	50	6
Total	62	63	58	5
All Services				
7 High Occupancy Hospitals	87	88	85	3
7 Low Occupancy Hospitals	78	79	75	4
Total	83	84	80	4

OCCUPANCY LEVEL

- Does the proportion of private, semiprivate and ward beds approximate the proportion of private, semiprivate and ward patient days?
- Does the proportion of maternity, pediatric and medical-surgical beds approximate the proportion of maternity, pediatric and medical-surgical patient days?
- For any other type of bed allocation, does the proportion of beds fit the proportion of patient days?

5. Can fluctuations in census be reduced by judicious management of waiting lists?

- What proportion of admissions was not emergency or urgent, and therefore was subject to scheduling at the convenience of the hospital as well as the patient and physician?
- Is a waiting list maintained as a matter of policy?
- Are any records maintained on the composition of the waiting list and on how long patients must wait for admission?
- Is there any record of elective patients on the waiting list who went to other hospitals or were not admitted for other reasons?
- Is there evidence of hardship to any patients resulting from the management of the waiting list?
- How many fewer beds would have been needed last year if the average period that elective patients were on the waiting list was increased by one day, with resulting reduction of admissions on relatively high census days?
- During how many calendar days last year were there patients on the waiting list at the same time that bed vacancies existed for some of these waiting patients?
- Is 24 hour advance notice of discharge required of attending physicians?
- Is there an enforced check-out hour?

6. Is it possible to encourage more admissions on Thursdays and Fridays and fewer admissions on Sundays and Mondays?

- Is assignment of operating room time to surgeons excessively rigid?
- Do these assignments have the effect of raising census on certain days of the week?
- Is there a Saturday operating room schedule?
- Is there adequate coverage of laboratory, x-ray and other services over week ends?

7. Are efforts made to encourage continuous availability of attending staff service?

- Are medical staff members encouraged to "stagger" holidays? Vacations?

8. Do cooperative arrangements exist with neighboring hospitals to even out census peaks?

- Can regular procedures be developed whereby the admitting office helps physicians with multiple staff appointments to admit some patients to another hospital when the census is high?
- Is there a mechanism for planning the coordination of services with neighboring hospitals?
- Can arrangements be made with another hospital to provide maternity or pediatric service at one location? ■

Death of Actor in Hospital Produces Gossip and Charges From Hollywood

Will O'Neil

CULVER CITY, CALIF. — A piece of brown wrapping paper in the hands of a group of rumor-ridden actors and a long-distance telephone call by a Los Angeles newspaper reporter to the chief of the California bureau of hospitals brought about a major headache for Culver City Hospital, where Jeff Chandler, movie actor, died.

The headache centered on David M. Brotman, M.D., who is the owner, president, treasurer, *de facto* administrator and medical director of the hospital.* He resents mention of his proprietary interest and prefers to be identified as the medical director of his institution.

Mr. Chandler underwent surgery in Culver City Hospital on May 13, 1961, for removal of a ruptured spinal disk by a neurosurgeon. Five days later a team of surgeons spent 7½ hours and 55 pints of blood on the stoppage of a massive hemorrhage. On May 27 they operated again to stop new bleeding and on June 8 for "acute cholecystitis."

Mr. Chandler died in Culver City Hospital on June 17. The death certificate gave "shock, peripheral vascular collapse" as the immediate cause of death, and "staphylococci septicemia, pneumonitis and bone marrow depression" as contributing causes.

Almost immediately after the first surgery (May 13) a massive hemorrhage of gossip burst across Hollywood and the movie studios. Wild rumors went beyond the improbable and into the impossible in allegations about the treatment of Mr. Chandler.

The gossip found a focus in the last week of June when a group of movie people at one studio prepared a crudely lettered petition on a piece of brown wrapping paper calling upon the Screen Actors Guild, an A.F.L. union, to investigate the circumstances of Mr. Chandler's death. The 152 signers of the petition asked:

"Was the death of Jeff Chandler due to negligence, incompetence, error or mitigating circumstances?"

The day following publication of the news of this petition a Los Angeles newspaper reporter telephoned Gordon Cumming, chief of the state bureau of hospitals, at his Berkeley office and asked Mr. Cumming what, if any, action the bureau was taking. The bureau would investigate the circumstances of Mr. Chandler's death, Mr. Cumming was quoted as saying, "to verify that standards of hospital care established in the state hospital licensing program were complied with fully in this case."

The bureau of hospitals' investigation and report were completed in early July, but the bureau must keep the report confidential until Sept. 15, 1961. On that date a new amendment to the hospital licensing act becomes effective and opens the bureau records and reports to public inspection.

(This amendment, quite apart from its application in the Chandler-Culver City Hospital case, was received with something less than enthusiasm by California hospitals. Hitherto confidential information about each hospital that now will become a matter of public record includes license application information relative to identity and character of the applicant, basic financial information, annual bureau inspection reports, and annual statistical reports required from each hospital. The new law, however, specifically prohibits disclosure of an inspector's work sheets or of information involved in the individual physician-patient or hospital-patient relationships.)

Seven-story addition rises behind the Culver City Hospital, Culver City.

The board of directors of the Screen Actors Guild deftly fielded the demand for an investigation to the bureau of hospitals and to Attorney Edward M. Rose, executor of Mr. Chandler's $600,000 estate. Mr. Rose was running his own investigation as a preliminary to deciding whether to file a malpractice suit against the doctors and/or hospital concerned.

There appeared to be nothing to indicate justification for such a suit in any official investigative information made available to the public in the early part of July.

But rumor and conjecture about the circumstances of Mr. Chandler's death continued at a high level. The press agent for the Screen Actors Guild, for example, said the S.A.G. had received "hundreds of phone calls and hundreds of letters about the case — more mail and more phone calls than we've ever received about anything in the history of the Guild."

Meanwhile Dr. Brotman, in his capacity of medical director of Culver City Hospital, was issuing a statement that Mr. Chandler had been attended by the best medical talent available in the Los Angeles area.

Dr. Brotman also defined the functions of a hospital for the press and asserted that Mr. Chandler "was given the best hospital care that modern technics can provide." The hospital is accredited by the Joint Commission on Accreditation of Hospitals, subscribes to the "Guiding Principles for Hospitals" of the Hospital Council of Southern California, and is a member of the Council, the California Hospital Association, and the American Hospital Association.

Dr. Brotman is building a seven-story, 150 bed addition to his present 130 bed plant. He has also announced that he will remodel his current facilities to provide additional surgeries and ancillary services and that he will build a seven-story medical office building and garage next to his hospital.

What effect the Chandler case may have on this program remains to be seen. ■

*Dr. Brotman also was listed as president of a corporation formed to purchase Gardena Hospital, a 70 bed proprietary hospital in Gardena, a near-by community, at the end of 1960. He sold the 100 bed Valley Doctors Hospital in Hollywood last spring.

Mr. O'Neil is a science writer, Santa Monica, Calif.

How To Make Sure 'Big Charges' Are Posted

This daily report form makes it easy to keep track of charges for the expensive basic hospital services

Robert H. Reeves

WHEN a patient isn't billed for all hospital services rendered because of an inadequate charging system, it's like throwing money out the window. The loss to the hospital is obvious.

Although most hospitals are concerned about proper charging methods for special services, such as x-ray, laboratory examinations, and so forth, it has been my experience that they often spend little time proving the posting of charges for the more expensive services — bed, board and routine care.

I have found one procedure that has been successful for many years in both large and small hospitals for accurate control and posting of daily service charges. Here is how it works:

A daily report form lists each room or bed in the hospital along with its established rate. The accompanying sample form is similar to one in use in a hospital that has 26 beds and six bassinets. The form shows the total dollars of income that would be earned if every bed and bassinet were occupied.

In daily posting of service charges, unoccupied beds and bassinets are indicated on the form and their dollar value deducted from the total possible income shown on the form.

Space is provided for entering charges amounting to more or less than the established rate. For example, the sample form shows that Patient Burns was charged $1 less than the established rate for his bed. This was because of a misunderstanding on the part of the hospital and the change is clearly shown on the daily report.

The form ensures that daily service charges for all occupied beds in the hospital are posted to the patients' accounts.

The procedure requires that the hospital maintain an accurate visible bed index. The bed index should not be changed for admissions and discharges occurring after midnight until the daily service rate report form is completed and posted for the day.

If a hospital operates a well integrated inpatient register, visible bed index, and discharge register, it is in an excellent position to use the simple procedure described here. ■

DAILY SERVICE REPORT FORM
Day ending at 11:59 p.m., March 13, 1961

Medical Unit		Surgical Unit		Maternity Unit		Nursery
Rm. No.	Charge	Rm. No.	Charge	Rm. No.	Charge	Charge
1	$20	11	$20	21	$23	$7
2	21	12	20	22	20	7
3	21	13	21	23	23	7
4	20	14	25	24	20	7
5	20	15	20	25	20	7
6	20	16	20	26	21	7
7	20	17	20			
8	20	18	24			
9	20	19	24			
10	20	20	23			

	Total
100 per cent occupancy	$588
Less empty rooms underlined	167
Gross earnings at regular rates	421
Exceptions as follows:*	
Richard Burns (Rm. 14)	(1)
Gross earnings per this report	$420
Gross earnings per income journal	$420

*Exceptions include rate charged other than established rate, part day charged instead of full day, charge to patient admitted and discharged on the same day, and so forth. Show patient's name for each such entry.

This form completed by:

(signature) (date)

Underscoring on sample form indicates unoccupied beds and bassinets. In practice, these could be crossed off or circled. Their dollar value is deducted.

Mr. Reeves is an accounting consultant for the Rochester Regional Hospital Council, Inc., Rochester, N.Y.

ABOUT PEOPLE

Administrators

Delbert L. Price has been appointed vice president of Gordon A. Friesen Associates, Inc., hospital consultants, and will join the firm in Washington, D. C., September 1. Mr. Price has been administrator of Children's Memorial Hospital, Chicago, for the last 10 years. Previously, he was assistant administrator of Butterworth Hospital, Grand Rapids, Mich. Mr. Price is a member of the board of regents of the American College of Hospital Administrators, a member of the house of delegates of the American Hospital Association, and past president of the Illinois Hospital Association, the Chicago Hospital Council, and the University of Chicago Hospital Administration Alumni Association. Mr. Price is a lecturer in the hospital administration program at the University of Chicago.

Delbert Price

Warren S. Hinton has been appointed administrator of Methodist Hospital and Medical Center, St. Joseph, Mo. He succeeds **O. J. Carder,** who retired after 36 years in that position. Mr. Hinton has been assistant administrator of the hospital since 1952. He is a graduate of the program in hospital administration at St. Louis University and is a fellow in the American College of Hospital Administrators.

Warren S. Hinton

Leon Bennet-Alder became executive administrator of Winter Park Memorial Hospital, Winter Park, Fla., August 1. Before accepting the Winter Park appointment Mr. Bennet-Alder was administrator, Chicago Osteopathic Hospital, and business manager, Chicago College of Osteopathy. He received his master's degree in hospital administration from the University of Toronto.

Gordon Boughton, administrator of Marion General Hospital, Marion, Ind., has accepted the position of administrator of Madison County Memorial Hospital, Anderson, Ind.

Henry Boyd has been named administrator of East Bolivar County Hospital, Cleveland, Miss., a 100 bed hospital now under consruction. Mr. Boyd resigned as administrator of Parkview Hospital, Dyersburg, Tenn.

Andrew Talley became administrator of Grady Memorial Hospital, Chickasha, Okla., in June. Formerly administrator of Clark County Memorial Hospital, Arkadelphia, Ark., Mr. Talley recently completed his term as president of the Arkansas Hospital Association.

Andrew Talley

Samuel Samuels has resigned as administrator of Memorial Hospital, Evanston, Wyo.

James Thomas, formerly assistant administrator at Tucson Medical Center, Tucson, Ariz., has accepted the administratorship of Sunrise Hospital, Las Vegas, Nev. **Rex C. Magee** succeeded Mr. Thomas at Tucson.

Sister Elizabeth, administrator of St. Mary's Hospital, Evansville, Ind., has been transferred to St. Paul Hospital, Dallas.

Sister Theodore Marie has returned to Sacred Heart Hospital, Eugene, Ore., as administrator. She had been administrator of that hospital from 1940 to 1955. She succeeds **Sister Marie dePazzi.**

James A. Gildea has been appointed superintendent of Coaldale State Hospital, Coaldale, Pa., succeeding **William B. Sheerin,** who died recently.

Arnold Hanson has resigned as administrator of Provident Hospital, Fort Lauderdale, Fla.

Jerry Poole is the new administrator of Brokaw Hospital, Normal, Ill. He had been assistant administrator of Blessing Hospital, Quincy, Ill.

R. J. Weinzettel, administrator of Memorial Hospital, Waycross, Ga., since 1955, has resigned to accept the position of administrator of Memorial Hospital of Chatham County, Savannah, Ga., effective September 1. Mr. Weinzettel received his master's degree in hospital administration from Northwestern University.

Sister Mary Margaret, administrator of St. Benedict's Hospital, Salt Lake City, since 1946, has resigned because of ill health. **Sister Estelle,** the purchasing agent, will succeed her.

Robert J. Marsh is the new administrator of Warren A. Chandler Hospital, Savannah, Ga. Previously, Mr. Marsh was administrator of Staats Hospital and Clinic, Charleston, W. Va., and executive director of Blue Cross and Blue Shield, Huntington, W. Va. He received his master's degree in hospital administration from Northwestern University.

Benita Cirulis has been appointed director of St. Luke's Convalescent Hospital, Greenwich, Conn. Miss Cirulis completed her studies in hospital administration at Columbia University this year.

William Mitchell has been named administrator of Carmi Township Hospital, Carmi, Ill. He formerly was administrator of Methodist Evangelical Hospital, Louisville, Ky.

Dr. J. Wade Marshall is the new administrator of Division Hospital, Lake City, Fla., succeeding **J. E. Hodges.**

Jerry Medanich is the new administrator of Forsyth Memorial Hospital, Tallahassee, Fla., succeeding **F. G. Winters,** who retired.

William A. McLees, Ph.D., has been appointed assistant administrator at Indiana University Medical Center, Indianapolis. He was previously with the research program of the Conference of Rehabilitation Centers and Facilities, Inc., Evanston, Ill. Dr. McLees is a graduate of Drake University and received his M.A. and Ph.D. degrees in hospital administration from the State University of Iowa, where he also was an associate professor in the graduate program. (*Continued on Page* 154)

William McLees

End result of blood processing: beginning of health for heart surgery case.

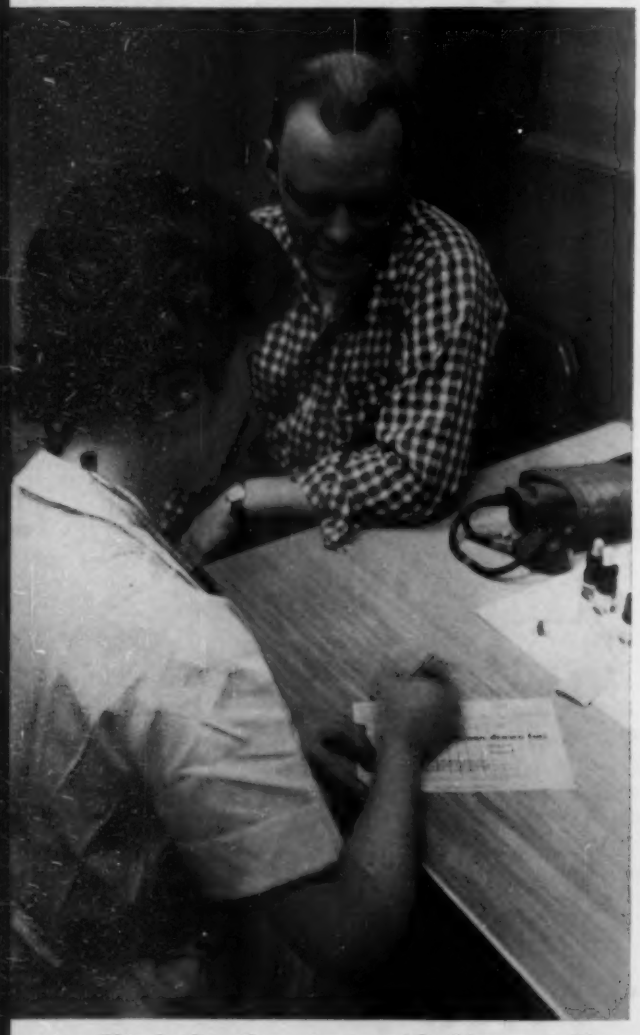
Rigid screening and meticulous care in processing technics prevent bad blood between donor and patient

Blood Centers Bank on Good Technics

Jane Barton

Production of blood and blood products is becoming a major industry. Every one of the estimated 5 million pints of blood poured into patients in the course of a year must be processed with exquisite care. What happens to a pint of blood from the time it is drawn at Michael Reese Research Foundation, Chicago, until it reaches the patient is shown in the succeeding four pages and on this month's cover.

Photographs by David E. Doty, Chicago.



Blood donation starts with history taking.

Donor: _____ Born _____ Wt.: _____

Address _____ Tel.: _____ Bus. Tel _____

Syphilis ☐ Malaria ☐ Resided in Malarial Area ☐ _____ Tuberculosis ☐ Allergy ☐
Jaundice ☐ or exposed last 6 mos. ☐ Gave blood last 2 mos. ☐ Sick last 2 mos. ☐ Pregnancy last 6 mos. ☐ Injections last 6 mos. ☐
Convulsions ☐ Heart Disease ☐ Head Injury ☐ Breathing Difficulty ☐ Chest Pain ☐ Paralysis ☐ Ulcers ☐ Blood and Blood Prod. Last 6 mos. ☐ Surgery ☐ (Date and kind)

Remarks:

LAB. No.	DATE	BY	TAKEN WHERE	C.C. BLOOD	NOTES	HISTORY CHANGES (JAUNDICE)	WT.	HEMO GLOBIN	B.P.	P.	TEMP.	BLOOD GROUP (UNIV.)		EARN	PD.	CHECK No.

This blood specimen drawn for:

Patient at

Hospital

I, the undersigned, hereby certify that I have full knowledge of and do hereby give my express consent to submit to the operation of blood transfusion as donor to any recipient under the direction of Dr. A. E. Wolf, and in consideration of the blood therefrom granted me by Michael Reese Research Foundation, I, the undersigned, do hereby release the said Dr. A. E. Wolf and the Michael Reese Research Foundation from any and all claims of any kind and nature that I may now have or that I might have against either of them in any way hereafter as the result of said operation, or because of the same or because of anything arising in connection therewith, and I do further authorize the aforesaid Dr. A. E. Wolf and the Michael Reese Research Foundation without further notice to release information concerning the Donor and the characteristics of my blood to the organization for which I am serving as a donor.

Signed _____

Witnessed by: _____

Dated at Chicago, Illinois _____

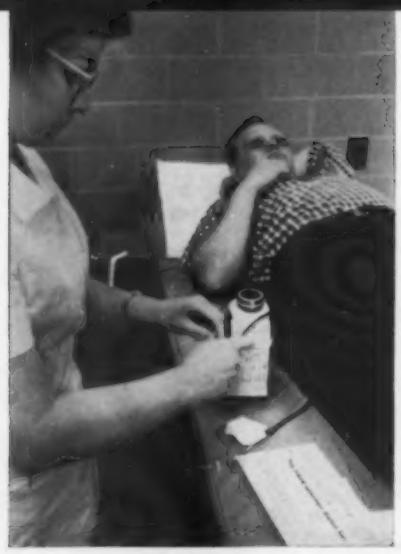
I certify that the above named donor is free as far as can be determined clinically, including personal history and physical examination, of any disease transmissible by blood transfusion.

Date _____ Name of Physician _____

Michael Reese Research Foundation, Chicago

Donor card is key to record system.

Donor's blood is mixed with citrate.



Venesectionist tags blood bottle.

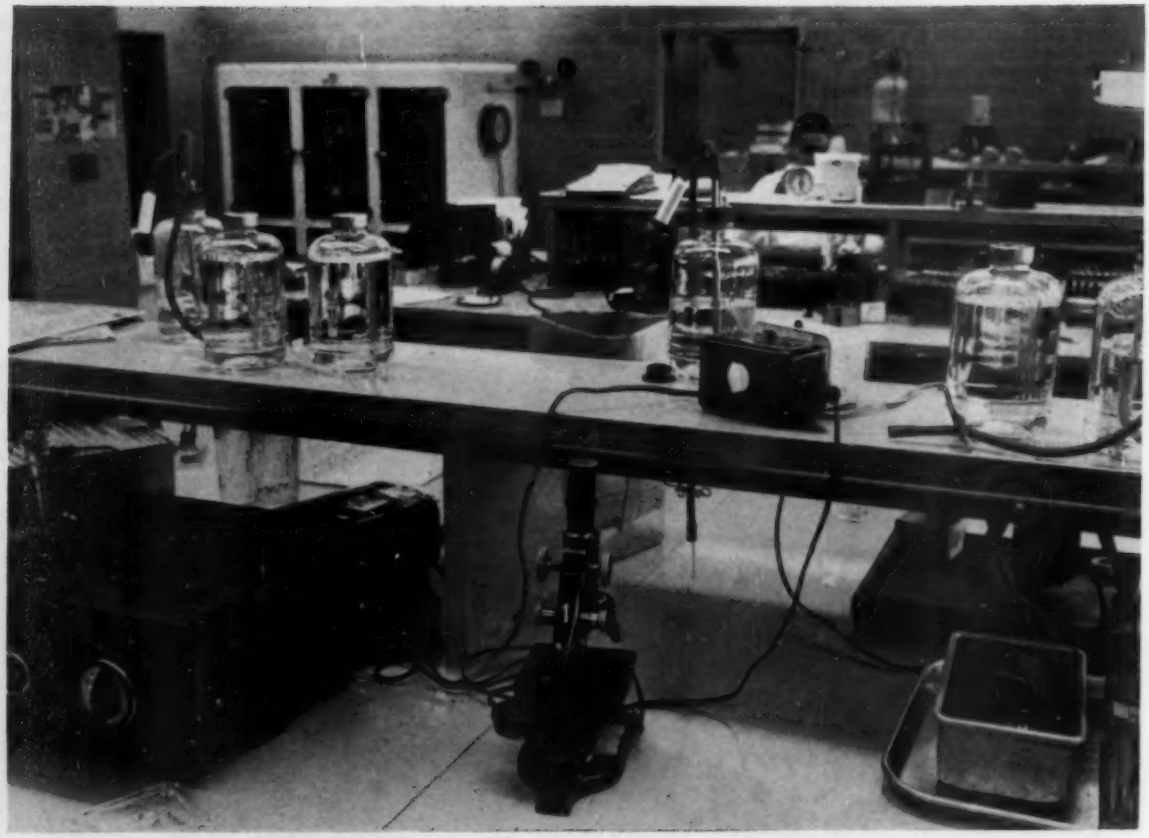
Tubes are filled with donor's blood.

Protection of Both Donors and Patients Is Partly a Matter of Accurate Records

Not everyone who wants to give blood should. Intense scrutiny of a donor's physical condition is essential for his sake and the recipient's. At Michael Reese Blood Center (as in others all over the country) the donor is questioned closely about his medical history and his answers are recorded on the donor card shown, which also serves as a release form absolving the Center of liability. Some of the questions, says Dr. A. M. Wolf, director of the Center, are designed to tell more about the donor than he knows about himself. During the bleeding process, the blood is mixed with citrate in a rotating machine. When the bottle is filled, it is sealed and labeled with a tag on which laboratory findings will be recorded. Three tubes are filled with blood from the drawing tube and accompany the bottle to the laboratory. Blood from one of these tubes is used for the tests so the bottle need not be opened until the blood (assuming it has passed all tests) is administered to the recipient.

(Continued on Next Page)

Donors visit over a cup of coffee.



Blood runs gamut of laboratory tests before it is approved for use.

Technician makes test for syphilis.

Laboratory Tests Determine Whether the Blood Is Suitable

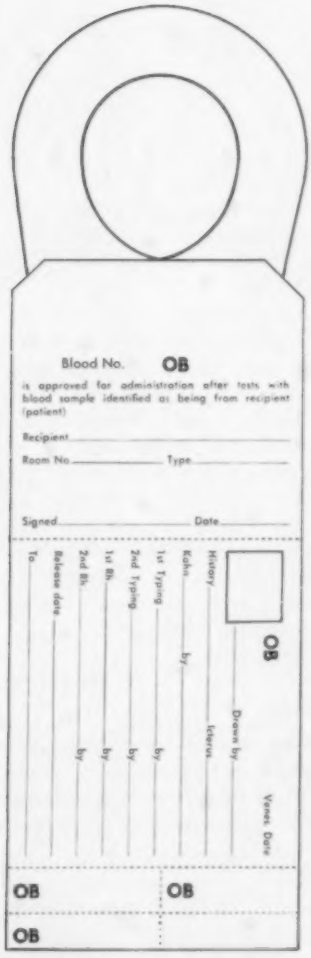
When the blood has been drawn and bottled, the laboratory takes over to decide whether it will be suitable for use. First, blood group and Rh are determined. Rh negative blood gets additional special tests. If sensitization tests on Rh negative blood show that donor has been sensitized to Rh factor, it is discarded. Blood is also screened for syphilis, malaria and hepatitis. The icterus index determines whether bilirubin test will be made. An unsatisfactory bilirubin test, a positive Kahn test, or fatty clots in the blood will cause it to be discarded. Tests are made on blood from one of the three tubes attached to the bottle. One tube goes with the bottle, and the third is labeled and stored for 24 days in case some question arises about the blood.

Technician reads blood group.

Two People Check Each Process

One bottle of blood looks much like another, hence, the necessity for positive identification. At Michael Reese a tag that carries a code number (which matches donor's history card and the label on the bottle and accompanying test tubes) is affixed to the neck of the bottle as soon as blood is drawn. One section stays on the bottle and one, on which test results are recorded, is detached and used as a work ticket. Ticket and donor's card are kept in file for reference. All tests and records are checked by two people. ■

Blood is tested for Rh, negative or positive.



Tag is affixed to all blood bottles.

Final check of blood before it goes to patient.

Modern Hospital Law

What Courts Have Said About Patient Consent

When patient's consent for medical or surgical procedures is not explicit, the doctor and hospital may run into some legal complications

John F. Horty

THE rule that a physician who performs an operation without the patient's consent is liable for a battery is widely accepted by the courts. It is therefore necessary that both the physician and the hospital be able to prove that adequate consent has been obtained before a medical or surgical procedure is undertaken. The legal rules with respect to what is required to prove a consent to the original procedure are quite definite. However, what constitutes consent to an extension or alteration of that procedure is far from settled. And, the jury must always determine whether the evidence presented shows that the required consent was obtained.

John F. Horty

When a doctor tells a competent adult patient that an operation is necessary, and the patient assents to this operation (perhaps signifying by a written statement to that effect), there is no question but that the operation was authorized.

When there is express consent to a specific treatment, and nothing further than this specific treatment is undertaken, the only problem is proving that such express consent was given. This may be accomplished by testimony showing the oral consent of the patient or by the introduction of a written statement signed by the patient, showing his express consent to the particular procedure. Consent forms satisfactory for this purpose will be discussed next month. For the remainder of this article, we shall discuss the legal problems presented by situations in which consent is not express and explicit.

When a patient submits to a procedure with actual or apparent knowledge of what is about to take place, but without any clear-cut verbal or written expression of consent, consent will be implied from such a voluntary submission.

Patient Must Be Fully Informed

If the patient is fully informed and apparently understands the nature and seriousness of the procedure, that is, if his actions and words, taken together, would cause a reasonable man to believe that he is consenting, then his voluntary submission to the procedure will be considered to constitute adequate consent. Upon proof of this, there is no need for a formal expressed consent, either orally or in writing.

A *Massachusetts* case indicates a situation where voluntary submission will constitute an implied consent. In this instance, the plaintiff, an immigrant, was a passenger aboard the defendant's ship. The ship's physician administered vaccinations to the immigrants. The court held that the plaintiff, by placing herself in a line to receive the shots, consented by implication to receive the vaccine. It was not disputed that the plaintiff knew what she was doing and had a proper understanding of what was being done to her.

Another example of a voluntary submission to treatment occurs when a patient, already in labor, presents herself at the hospital for the purpose of having a baby delivered. In this instance, consent to delivery and to the customary incidents of hospital and medical care necessary to effectuate the delivery can be implied from the patient's presence at the hospital for treatment. Depending upon how far advanced labor is at the time the patient enters the hospital, an emergency, which obviates the necessity for obtaining any consent, might also be shown.

The consent implied from voluntary submission to treatment is limited to the particular treatment contemplated by the patient and the physician.

It is necessary, when the patient is advised of the planned procedure, that he be furnished an explanation of the consequences in order to ensure that a voluntary submission constitutes consent. Voluntary submission based upon intentionally incorrect or

---

John F. Horty is director of the Health Law Center at the University of Pittsburgh.

This is the second article in a series on consent. The first appeared in the July issue.

arresting measure for surgical bleeding

When the customary surgical techniques for capillary hemostasis fail, prompt cessation of oozing may usually be obtained with OXYCEL (oxidized cellulose, Parke-Davis). This absorbable hemostatic conforms readily to all wound areas...assures a clear operating field...helps to shorten operative procedures.

Available in forms for every need: OXYCEL (oxidized cellulose, Parke-Davis). Pledgets (Cotton-type), 2¼ in. x 1 in. x 1 in.; Pads (Gauze-type) (8-ply), 3 in. x 3 in. and 4 in. x 12 in.; Strips (Gauze-type) (4-ply), 5 in. x ½ in., 18 in. x 2 in., 36 in. x ½ in., and 3 yd. x 2 in.; Foley cones (Gauze-type) (4-ply), 5 in. and 7 in. diameters. Sterile as supplied.

Indications: As an adjunct to effect hemostasis in bleeding associated with capillary oozing. ***Use:*** Strips—temporary packing of bleeding cavities, nasal passages, and tooth sockets; pads—temporary packing of surgical beds as after biopsies and to cover more or less extensive areas as in laparotomies; pledgets—in neurosurgery and in dental work for small localized bleeding areas; Foley cones—in prostatectomy.

Precaution: Excess amounts should be removed prior to surgical closure to avoid foreign-body reaction. Not to be used in sites of infection or following silver nitrate or other escharotic chemical agents. Contraindicated in clean bone surgery when poor vascularization is present and in instances where rapid callus formation is desired. Should be used sparingly in open reduction of fractures and in cancellous bone. Will not withstand heat sterilization. Remove from container aseptically.

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absorbable hemostatic

OXYCEL

insufficient information cannot constitute consent. The patient's lack of knowledge of the nature or consequences of the procedure overcomes any evidence of expressed consent or of voluntary submission, because, in fact, the patient has not consented to the procedures actually adopted.

Thus, there is an obvious danger in relying upon voluntary submission as proof of consent to any complicated procedure. Neither the hospital nor the physician should rely upon this alone. Failure of the jury to believe oral testimony regarding the patient's knowledge of the consequences will destroy the defense of consent, in spite of the patient's submission to treatment.

Even though an express consent to surgical procedure exists, questions may arise involving the necessity of proving a patient's consent to an extension or alteration of the original procedure.

Additional consent is necessary when conditions are discovered during treatment which were not anticipated when consent to the original procedure was procured. The difficulty is to determine the circumstances under which consent to the extension, modification or alteration can be implied from the original consent or from the physician-patient relationship.

When an incision is made, the preliminary diagnosis may be found to be incorrect. At that time, the patient may be anesthetized and incapable of consent. The question arises whether the physician may perform a different operation in order to relieve the actual malady. Or, the original diagnosis may be correct, but during the course of the operation another condition is discovered which requires surgery. Let us assume that in both instances no emergency exists, but that the conditions which are discovered call for correction if precepts of good surgery are to be followed.

In the following paragraphs I will discuss circumstances under which consent to an extension, modification or alteration of a certain procedure has or has not been found by the courts.

If a patient expressly prohibits a certain medical or surgical procedure, an implied consent for such a procedure cannot be shown.

Therefore, if a patient expressly prohibits any extension, alteration or modification of the original procedure for which consent was given, the physician has no right to assume that any consent exists that will protect him should he proceed. Where there has been no express prohibition of an extension, modification or alteration the law is unclear with respect to whether consent to such an extension can be implied. Some courts take a strict view and hold that when a physician is authorized to undertake a certain surgical procedure and presumes to do an additional or altered one, he is liable for a battery, and cannot be relieved from liability by showing that the procedure was skillfully performed and resulted in benefit to the patient.

Radical Surgery Harmed Patient

For example, in a *Wisconsin* case, the physician stated that he would perform a "simple" mastoid operation. He actually performed a "radical" mastoid operation that caused harm to the patient. The court stated that a consent for a radical operation could not be implied from authority to perform a simple operation.

In a *Rhode Island* case, a patient's consent to an operation described to him as intended to strengthen the ligaments holding the spleen was held by the court not to constitute consent to remove the spleen. In that case no evidence was introduced to show that the actual operation was a pathological necessity, nor reasonably incidental to the authorized operation.

In an *Ohio* case, the patient consented to an appendectomy. During the operation the physician performed an ovariotomy, justifying his action by testimony that he found the ovaries and Fallopian tubes to be diseased. The surgeon was held liable for removing them without consent.

However, other cases have held that there may be an implied consent to extend, modify or alter the medical or surgical procedure depending upon the nature and circumstances in which the original consent was given.

In a *New York* case, the plaintiff's doctor told him that his hernia probably was on the right side but he could not be certain until surgery was under way. Plaintiff consented to the operation which, in fact, necessitated operating on both sides. This consent was held to be sufficient because the nature of the ailment defied exact diag-

nosis, and the patient had impliedly consented to the treatmtent of his hernia through any surgery reasonably related to its relief.

In a *Washington* case, an express consent to a craniotomy was held to carry with it an implied consent to cease the operation if the tumor proved impossible to remove. The patient claimed that the surgeon performed an unauthorized exploratory operation instead of the authorized craniotomy. The court held that consent gave a right to the physician not to perform the operation if, after incision, he found further surgery would be dangerous to the patient.

In a *Wyoming* case, during the course of an appendectomy, the surgeon lost a needle. This fact was not discovered until the incision was closed. The patient was immediately examined by x-rays and the needle was located. The surgeon then reopened the incision and removed the needle. The court held that reopening the incision was not a separate or independent operation, but was incidental to, and part of, the main operation. The court also stated that had the surgeon left the needle inside his patient, it would have constituted negligence and that a jury could therefore find that the patient had impliedly consented to the surgeon's actions, taken to prevent future harm that might result from leaving the needle in her body.

A *North Carolina* case enunciates what might well be the best modern legal rule for cases involving extension of the original procedure. The facts of this case are as follows: During an operation to remove the patient's appendix, the surgeon, for sound medical reasons, punctured some cysts found upon the patient's ovaries although there was no express authorization to do so. The patient sued for assault and battery.

The court stated that during the period when the common law was being formulated, even a major operation was performed in the home of the patient and the patient was ordinarily conscious, so that the physician could consult with him about conditions which required or made advisable an extension of the operation. However, with the advent of modern hospitals and the widespread use of anesthesia, plus the fact that relatives are sometimes many floors away in the hospital, more and more courts are beginning to realize that it is impractical to consult with the patient and obtain a change in his consent.

The court then stated that in major internal operations both the patient and the surgeon know that the exact condition cannot be finally diagnosed until the patient is under anesthesia and the incision has been made. Consequently, in such a case, consent – in the absence of proof to the contrary – will be construed as general in nature and the surgeon may extend the operation to remedy any abnormal or diseased condition in the area of the original incision, whenever he, in the exercise of his sound professional judgment, determines that correct surgical procedure dictates and requires an extension of the operation originally contemplated.

In short, the court continued, where an internal operation is indicated, a surgeon may lawfully perform, and it is his duty to perform, such operation as good surgery demands even when it means a further extension of the operation than was originally contemplated, and for so doing he is not liable in damages for an unauthorized operation.

This rule, stated in this case, satisfies both the requirements of modern medicine and the necessity that the patient be able to determine his medical destiny. The surgeon does not have the privilege of performing an operation that is totally different from the one originally contemplated. Thus, an extension or modification must be reasonably related to the purpose of the original procedure, or if unrelated to the purpose because of a newly discovered condition, it must be closely related to the area of the original incision, and present no unreasonable additional risk to the patient.

Under no conditions should a procedure, determined upon by the surgeon prior to the administration of the anesthesia, but unrevealed to the patient, be permitted by the hospital. In cases where the surgeon has an opportunity to consult with the patient before commencing the operation, the patient, and the patient only, has the right to determine whether he desires to proceed. When the patient is able to consent he has the right to do so and the hospital should be certain that this right is protected.

In the next issue I will discuss forms which the hospital may utilize to make certain that adequate proof of the patient's consent is obtained. ■

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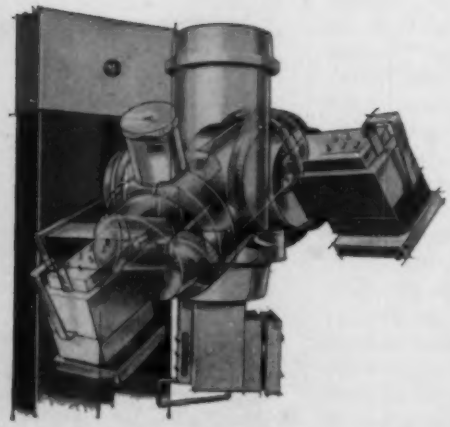

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On the pages following there's more about Maxitron 300, and your G-E x-ray representative has complete data. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Dept. H-82.

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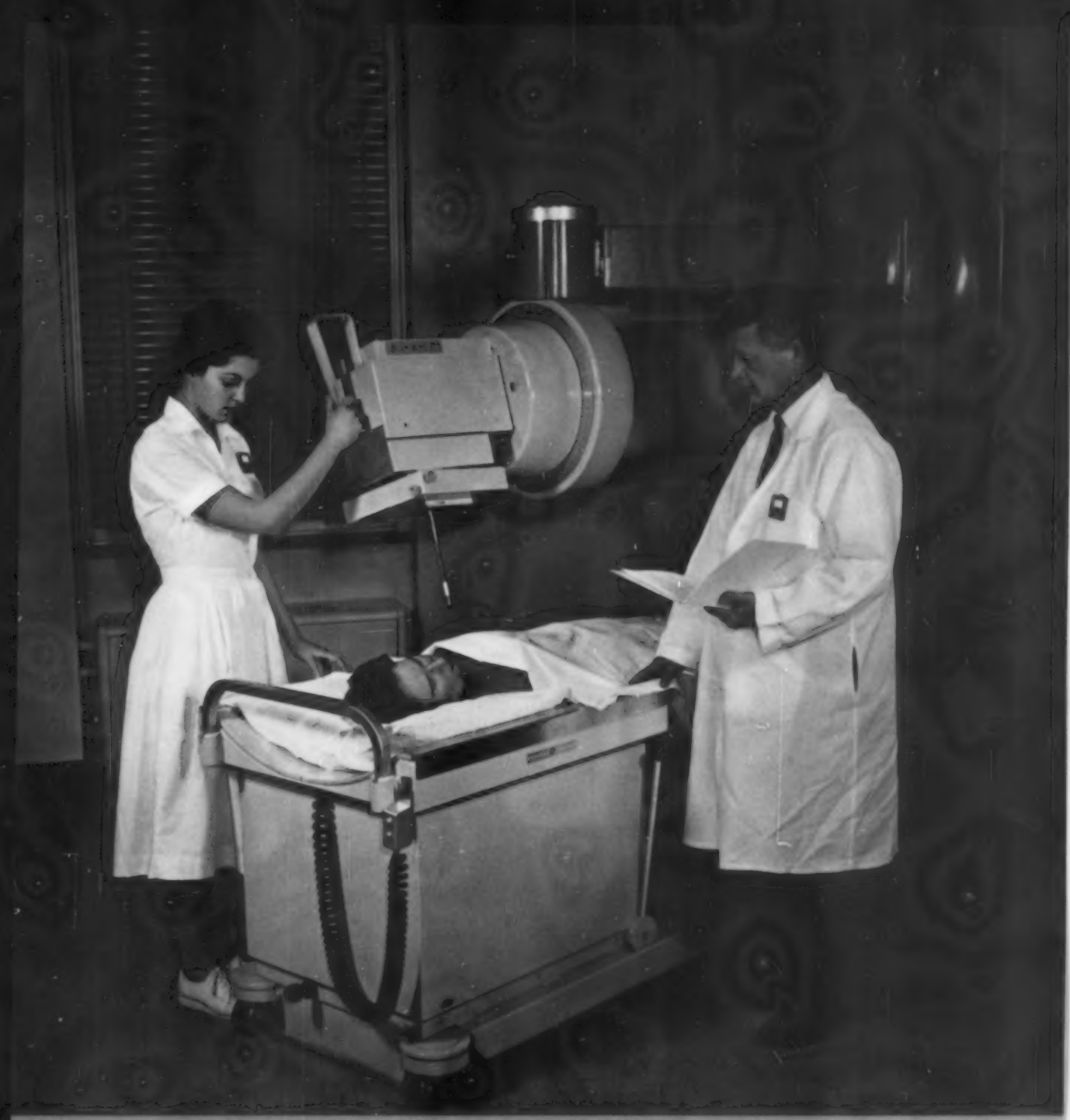

De Paul Hospital, Norfolk, Virginia—This Maxitron 300 x-ray therapy unit, like so many others of its kind from coast to coast, is in constant demand for treating cases in all categories. In this 300-bed Sisters of Charity hospital, the installation aids the Department of Radiology in gaining maximum utilization of precious floor space.

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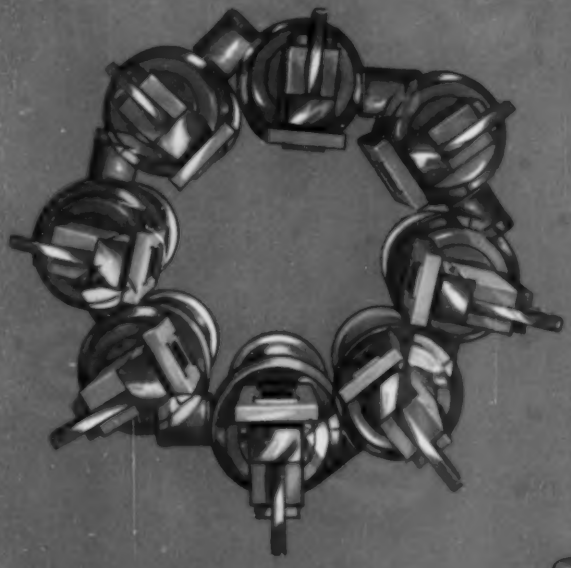
X-RAY THERAPY UNIT



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Pharmacists' Education, Experience Qualify Them for Committee Work

By Grover Bowles Jr.

AS HOSPITALS have increased in size and complexity committee activity has become more important. The pharmacist, by way of education and experience, is well equipped to participate in committee discussions from a professional, as well as an administrative, point of view.

It is generally accepted that the pharmacist will play an important role on the pharmacy and therapeutics committee.

As secretary and the only long-term continuing member of the committee the pharmacist does much of the leg work necessary for productive committee activity. The discipline acquired from service as secretary of this important group prepares the pharmacist for other committee work.

As a member of the committee on infection the pharmacist is in a position to assist in the development of proper sterilizing procedures.

His knowledge of the content, effectiveness and limitations of cold sterilizing solutions will assist the committee in developing proper procedures for the use of these preparations. The pharmacist's technical training in chemistry and microbiology will be most helpful in deciding what items should be sterilized by steam under pressure, hot air, ethylene oxide, and other processes. His knowledge of new therapeutic agents and his familiarity with the activities of the pharmacy and therapeutics committee will be helpful in preventing overlapping of work and duplication of effort.

The increased use of sanitizers, complex deodorants, detergents and a variety of other chemical compounds throughout the hospital has presented many new problems. Patients' safety as well as the safety of the employes using these materials must be considered. It is logical that the hospital's safety committee should expand its sphere of activity to include the proper handling and use of these agents. Since the pharmacist is specifically trained in this area and is the hospital's expert on chemicals, it is also logical that he should contribute to the development of safe routines for the proper handling, use and storage of these agents.

Today, many hospitals have product evaluation committees to survey the endless number of "labor-saving, cost-reducing" disposable products marketed for patient care. This group decides on the safety, suitability and practicality of these items and where indicated it undertakes pilot study on those items of particular interest to its hospital.

The pharmacist's scientific background combined with a thorough knowledge of business and marketing procedures makes him a valuable person to assist in the sifting of promotional information and arriving at objective decisions on the application of these products in his hospital.

When the pharmacist's responsibility is extended to include supervision of central sterile supply he should be included on the procedure committee or other group that determines what item should be on sterile trays and included in sterile packs.

Here his insight into the proper methods of sterilizing various supplies, packaging materials available, prepackaging and an appreciation for the paper cost involved in making supplies available qualifies the pharmacist for membership on this committee. ■

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Operating Room Forum

Proper Approach Is Necessary in Presenting Surgical Aide Program

By Frances Ginsberg, R.N.

NO NEW program can have acceptance or support without the understanding of those ultimately responsible for it and those who will be working with it. Nor can it succeed without a willingness on the part of those directing it to provide the necessary facilities and moral support. This is particularly true of a program designed to train surgical technical aides.

Frances Ginsberg

The trustees might well question the legal implications regarding responsibility. The medical staff might question whether such aides can be trained adequately to provide the type of service they require. The nurses might react to what they consider a threat to their security and status. Other employes might resent the opportunities offered to some and not others, and the public might react unfavorably to the idea that someone other than a nurse should be involved in their care.

No one except that person who will be responsible for the total program, or someone who has successfully carried out such a program, can adequately interpret and explain it to the satisfaction of these various individuals and groups. That person must be a nurse who has already gained support and cooperation for this effort from the administrator and the nursing service director.

The trustees must be shown that similar programs have been successfully carried out in other hospitals. If further proof is necessary, statements from the boards and legal counsels of these other hospitals should be made available to them.

A similar approach should be made to the medical staff. There are already a number of hospitals, both civilian and military, where surgeons would be more than willing to assure their questioning colleagues that surgical technical aides are providing excellent service.

Professional nurses should be shown how the surgical technical aides will supplement them without threatening their security, since the aides will work only under their direct supervision.

If properly presented to the other employes, the program will indicate that the hospital is anxious to give employes opportunities to advance in grade and responsibility. This can only result in better morale among all of the nonprofessional employes.

For the public doubts, the program can be equated with the recognized service being provided by nursing aides on patient units. The surgical technical aide, it can be explained, is the counterpart

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Miss Ginsberg is a consultant on operating room nursing and hospital aseptic technics and a member of the Bingham Associates Program at Boston's New England Center Hospital.

This is the third of a series of articles on surgical technical aides. The first two articles appeared in the June and July issues. The series will be concluded in September.

of the nursing aide in the operating and delivery rooms and in central service.

There must be an understanding on the part of the administration that certain factors must be considered. Teaching cannot be accomplished in a vacuum nor on a time-available basis. Adequate classroom space must be made available, as well as necessary teaching materials and teaching aids that are considered necessary to the program. Further, those selected to be in the program must be relieved of their duties for the period of training and retained as paid employes. ■

O. R. Forum Questions and Answers

Many readers have asked questions about specific technics, procedures and other matters dealing with operating room nursing and aseptic practice. These questions have been forwarded to Miss Ginsberg and, since many of them were of general interest, she has agreed to answer them in this special section. Questions regarding operating room practice will be welcome and will be forwarded to Miss Ginsberg for reply in this column.

Chemicals Will Disinfect Thermometers

How and where should clinical thermometers be sterilized?

Hospitals that do not have an ethylene oxide sterilizer, which can be set at low temperature for an extended period, can effectively disinfect thermometers by chemicals. Some hospitals use the individual thermometer technic, issuing patients a clean thermometer on admission. The holder is filled with a mild quarternary ammonium compound, which is cleaned and refilled every three days until the patient is discharged. To make the unit safe for another patient, it should be terminally disinfected in central service. There the holder should be emptied, cleaned and autoclaved. The thermometer should be friction-rubbed with a detergent soaked sponge, rinsed in cold water, and soaked in a solution of ½ per cent tincture of iodine in 70 per cent isopropyl alcohol for 10 minutes. Following this, the thermometer may be removed, rinsed in cold water, dried and stored in a paper envelope or clean "boat" for future use. Other agents in adequate concentration for tuberculocidal action, such as synthetic phenolics and iodophors, may be used.

When individual thermometers do not remain at the patient's bedside, central service should issue a 12 or 24 hour supply of clean thermometers to each nursing unit.

Sterile Cans Aren't Sterile

Why do you oppose the use of sterile metal cans for 4 by 4 inch sponges used in an emergency room?

The objection in this case is not to the can but to its contents. Although when placed on its side with its cover off and exposed for 30 minutes at 250 F. the unit can be sterilized, there is no way to *keep* it sterile. Contamination results in proportion to the number of times the lid is lifted, as well as from the method of removing a supply of sponges. Any container with multiple unwrapped sterile items should be eliminated in preference to commercially packaged and sterile items or hospital wrapped and sterilized packages. Metal cans may be used for storing such sterile items. ■

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The Fall of the Hospital Bed Is Not a Laughing Matter

By Robert S. Myers, M.D.

EVERYTHING in life has its ups and downs, and apparently this is true also of the hospital bed, which is now getting nearer and nearer to the floor.

We are told that some 20,000 years ago, Neolithic man laid his grass mattress upon the ground, and this was his bed. With the passage of the centuries various refinements in the contents of mattresses probably were made, and it is likely that different means of elevating the mattresses from the ground were devised to protect the sleeper from dampness, insects and rodents. Certainly, we know that as early as 3000 years ago the Egyptians had invented movable beds with legs.

Since a bed was a bed in those early days, it is probable that the hospital bed was similar to the bed used for domestic purposes in any particular region, and certainly we know that wooden bed frames covered with feather mattresses were used in parts of Europe from the Eighth to the Eleventh Centuries. But from the Fourteenth Century on, we have some exact descriptions of hospital beds and these demonstrate a continuous improvement in the frame and its mattress. We know also that in 1818 an extra high hospital bed was invented to prevent back strain of hospital personnel caring for patients in United States military hospitals. By the turn of the Twentieth Century the hospital bed with mattress had probably reached a height of about 32 inches.

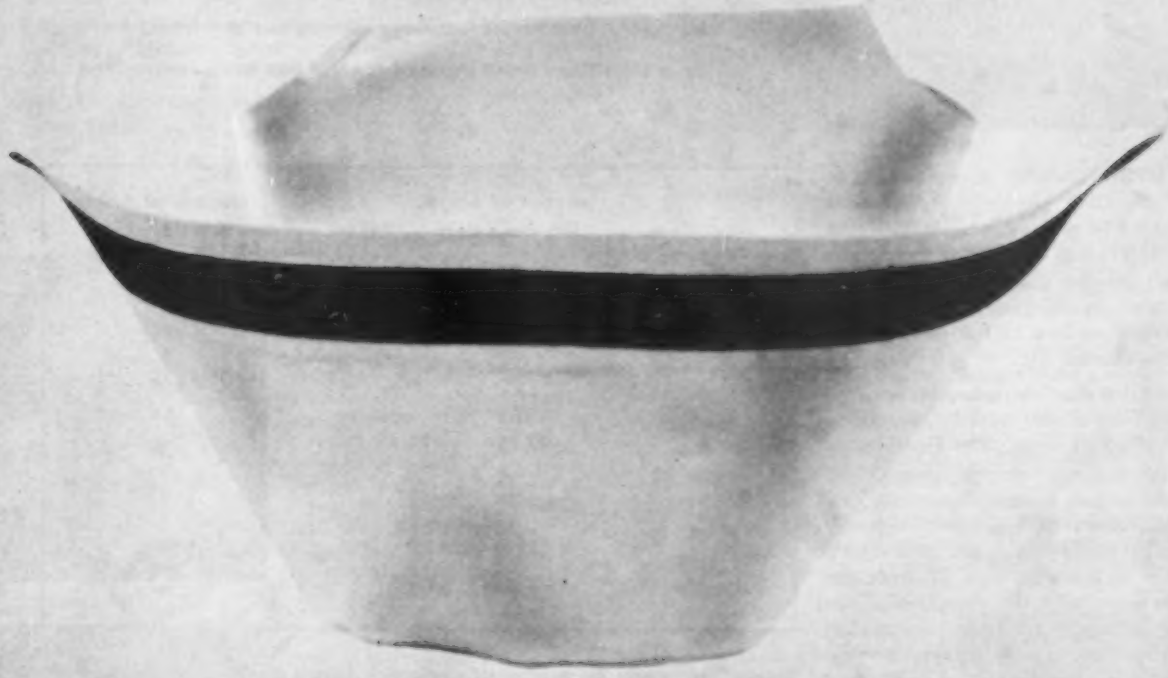
In 1924 the height of the hospital bed had been standardized at 27 inches from floor to top of springs (about 31½ inches with mattress), and it remained more or less at this height, depending upon the mattress and its casters, until the 1940's, when early ambulation necessitated the development of beds which could be raised to accommodate the personnel and lowered to permit the patient to get in and out safely. Thus was developed the hospital bed of varied heights which can be adjusted manually or by motor from 22½ inches to 31½ inches. It is estimated that 75 per cent of all hospital beds sold today are of this adjustable type.

All this progress has been highly desirable and is an indication of the intense interest of hospital administration and the medical staff in the welfare and comfort of the patient. But the sociologists apparently are not satisfied with these primitive aims. Now comes their desire to make hospital rooms more homelike, one phase of which is the convertible day bed or studio couch. Another phase is the live-in area for relatives. Either suggestion is enough to blanch the cheek of the staunchest administrator; together they could strike him down.

Maybe the wheel is coming full circle, and we will get back to the mattress on the floor. Or, perhaps, the social planners will be able to persuade us that the self-image of the patient will best be served if we go back to the granddaddy of all studio couches. This was the Bed of Ware, presented to Edward IV in 1463. It accommodated 102 sleepers, certainly a record for "togetherness."

Hospitals had better be on their guard; apparently, there are no limits to the designs these humorless people have upon us. ■

a lot of oxygen "know-how" is under this cap



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LINDE COMPANY UNION CARBIDE

Conducted by Jane Hartman

Simplified Schedule Keeps Track of Employes

This plan also keeps employes on the track and has reduced not only absenteeism and turnover but number of employes because work hours have been stabilized and employe control has been centralized

Mary Ortolano

IMPROVEMENT of two systems in the food service department at University of Michigan Hospital has saved $13,520. A year ago, the dietetic staff decided that improvement was needed in the schedules for food service workers in the patient food service areas.

At that time, the schedules involved 57½ food service workers assigned to 17 different areas. The employes in these serving kitchens cover a 13 hour period, from 6:30 a.m. to 7:30 p.m., seven days a week. Although the physical facilities and meal service differ in many of these 17 areas, the functions, with the exception of the formula and bottle rooms, are similar: (1) assembly of patient trays; (2) washing of the returned soiled dishes, and (3) cleaning of the kitchen area.

Cause of Absenteeism

The main concern was that these employes were working long stretches of time, in some cases a 10 day period, without a day off. This not only cut down the efficiency of the operation, but it appeared to be one of the causes of excessive absenteeism. The next concern was cost; extra people were scheduled in some areas for no apparent reason. Finally, there was a definite lack of control. The weekly schedules were written by nine different food service supervisors. Since there was no central area for reporting absenteeism and tardiness, there

1960	Number of Single Sick Days Used	1961	Number of Single Sick Days Used
January	41	January	29
February	32	February	19
March	34	March	23
April	32	April	20
May	29	May	19
June	33	June	14
July	25		
August	21		
September	21		
October	32		
November	29		
December	24		

Figure 1 compares the number of single sick days a month taken during 1960 with the substantially smaller number each month in the first half of 1961.

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Regular Position A	Day Off	Day Off	A	A	A	A	A
Regular Position B	B	B	Day Off	Day Off	B	B	B
Regular Position C	C	C	C	C	Day Off	Day Off	C
Relief Position	Day Off*	A	B	B	C	C	Day Off

*A relief replacement works position A on Monday

Figure 2 shows a one-week schedule for four positions, illustrating how days off are consecutively arranged under the new system, without staffing gaps.

Miss Ortolano is assistant director of the department of dietetics, University of Michigan Medical Center, Ann Arbor.

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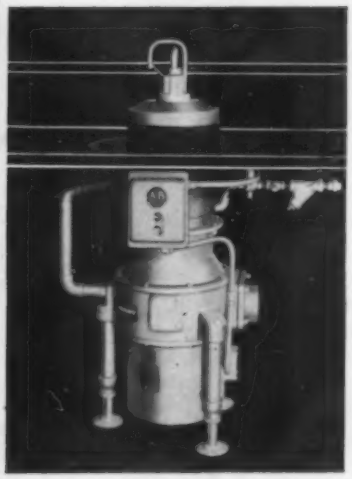

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This Schedule Suits Employes and Hospital

Figure 3 represents a portion of the completed schedule for four areas, showing how the individual schedules are arranged. In addition, the position schedules have been meshed to eliminate several extra persons.

was no follow-up or action taken in these cases.

The objectives for the revision were to be:

1. A shorter work stretch, preferably no more than five days.
2. Elimination of the extra personnel.
3. Reduction of absenteeism through better control.

It was hoped that a new schedule would incorporate these objectives and still assign the employes schedules they were accustomed to working. It would have to include:

1. Two days off in a work week; the work week at the hospital is Monday through Sunday.
2. Some week ends off.
3. The split days off should be kept to a minimum. Two days off in a week might mean a Monday and a Friday off rather than a Monday and Tuesday together.
4. As short as possible work stretch.
5. The coverage of all units but with no extra people, if at all possible.

At this time, it was also decided that two serving kitchens on one floor could be consolidated. As the total number of patient trays served from these two areas never exceeded 80, staffing two serving kitchens appeared to be an unnecessary use of personnel. One, therefore, was closed and all trays for the surgical floor are now being served from the one kitchen, with a saving in personnel.

Supervision Was Centralized

An industrial engineering student prepared a revised schedule which we felt could be used. After we discussed the revision with the employes, telling them why and how this would affect them, the new schedule was initiated May 2, 1960. At that time, centralized scheduling was also introduced into the system. One food service supervisor was given the responsibility for scheduling all the food service workers on the floor areas, finding replacements for shortages owing to absenteeism, follow-up for the cause of these absences, initial interviews with all applicants, and the formulating of workable employe records.

The revised schedule is based on a four-position system: three regular and one relief position plus the use of a relief replacement for one day per week. A portion of the new schedule, including four of the 16 areas covered, is shown at the top of this page.

In the year this schedule has been in effect it appears some real gains have been made:

1. Five positions were abolished, which eliminated the extra people who were assigned to all the areas, with the exception of one person three days per week.

2. Based on an average rate of $1.30 per hour, a saving of $13,520 per year was realized.

3. The number of employes who report "off sick" for one day has dropped.

4. Greater emphasis has been placed on frequent evaluations, greater job responsibility, and better job performance, which has eliminated many employe problems.

5. A more effective employe selection program and recommended dismissal of irresponsible employes have resulted in a lower turnover rate. The reported departmental rate was 4.3 per cent in July and 2.2 per cent in December of 1960. ■

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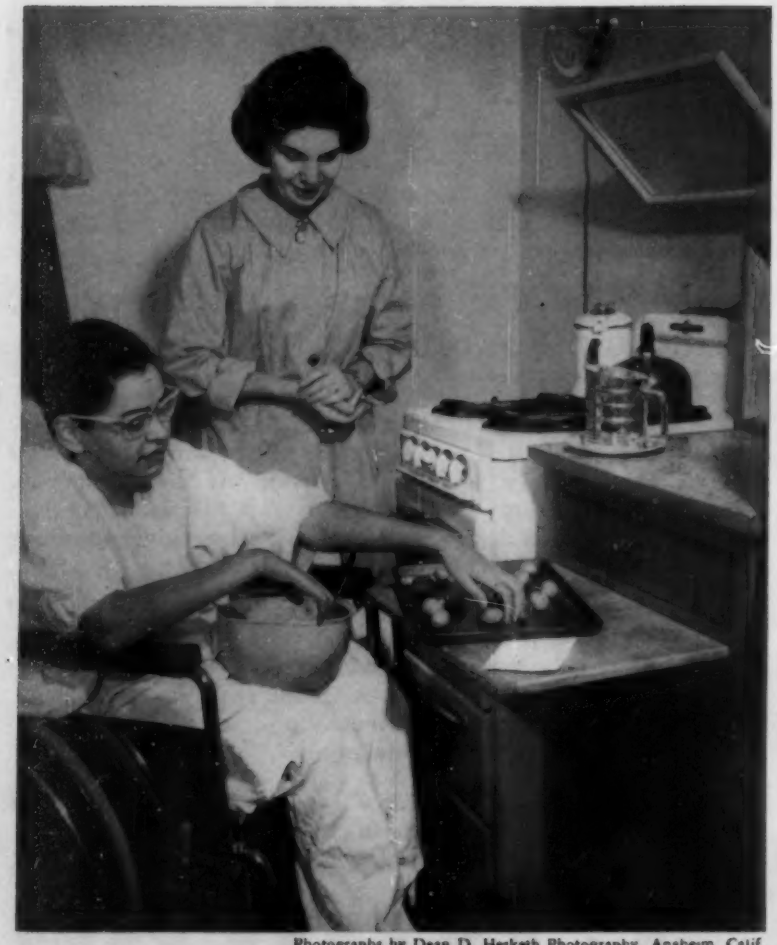
COLD STORAGE DOORS

Wheel-chair and ambulatory patients enjoy preparing their own luncheon once a week, and have even had success cooking for others in this unusual therapy program at Orange County General Hospital, Orange, Calif.

Patients Cook Their Way Back to Health



Photographs by Dean D. Hesketh Photography, Anaheim, Calif.

Forming balls of dough is good exercise for this patient — and brings its own immediate reward in the form of peanut butter cookies to share with friends.

Joan S. White

BEADS of perspiration stood out on the patient's forehead as he laboriously turned the handle of the can opener. There was a hiss of compressed air as it operated the artificial muscle that clamped useless fingers in place. He was doing the pushing himself with muscles seldom used during the year he had been hospitalized in bed.

Slowly the can turned. The perspiration dripped from his chin. The handle turned faster now until suddenly the can lid was off and this teen-age cook was well on his way to making his favorite dish – tamale pie.

Sharing the kitchen with him was an elderly lady bent on proving to everyone that she was ready to return to her own apartment to care for herself despite an arm paralyzed by a stroke. This cook was efficiently peeling a potato with her good hand. The potato was held stationary while she peeled because it was impaled on a nail hammered through the board on which she was leaning.

In an adjacent dining area several more patients in wheel chairs and one on a guerney were setting a table and arranging flowers in preparation for a luncheon meal that through their combined efforts would be ready

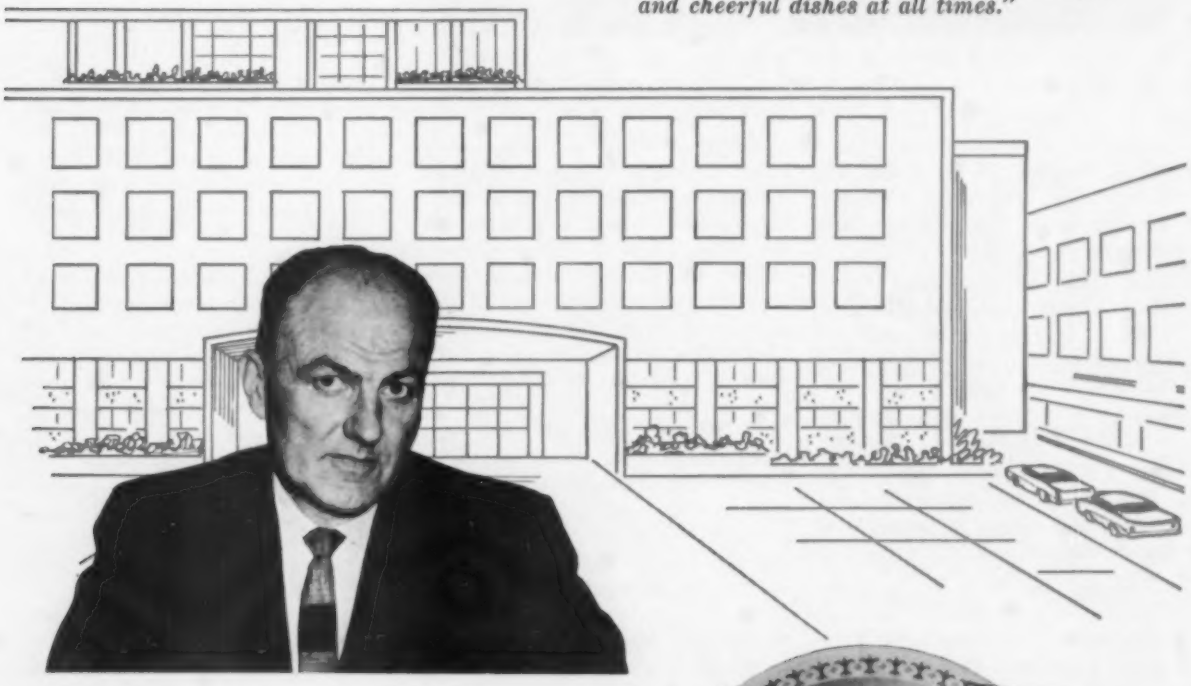
The author is a dietitian, Orange County General Hospital, Orange, Calif.

"Saved $4400 in replacement costs the first year with Regal Ware"

says Norman Anthony, food manager
St. Mary's Hospital
San Francisco, California

"In the ten years prior to our use of Regal Ware, our replacement cost for china averaged between $4,500 and $5,000 a year. The total cost for one-year's use of our Regal Decorated "Fleur-De-Lis" pattern dinnerware was just $76.85!" (Installation cost was easily paid for from first-year savings.)

"In the past 14 months our patient and cafeteria count has increased 40% — we are now licensed for 411 beds and serve 5,500 meals a day. Yet our payroll in the dish room has decreased due to ease of handling. Our Regal Ware is in excellent condition. We give attention to proper detergents, and have had no difficulty whatsoever in maintaining clean, bright and cheerful dishes at all times."



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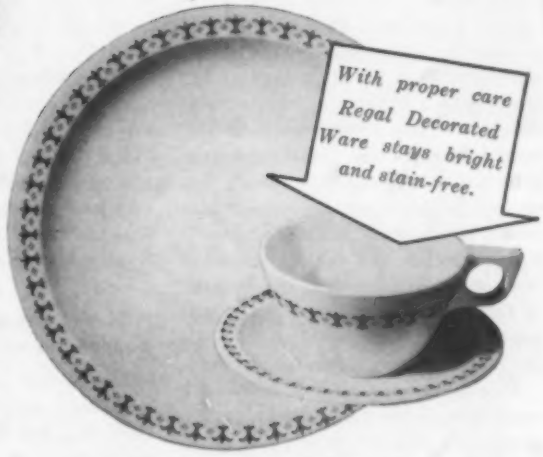
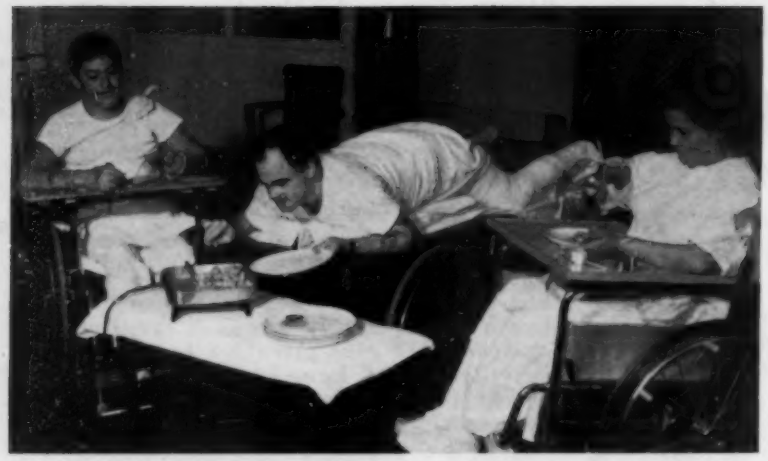


ST. MARY'S HOSPITAL SELECTED THE POPULAR "FLEUR-DE-LIS" PATTERN

REGAL WARE • DALLAS WARE • TEXAS WARE are products of PLASTICS MANUFACTURING COMPANY, 2700 S. Westmoreland, Dallas 33, Texas



Piano bench makes a convenient table for patient on a guerney. He dishes hash, which is salted by "cook" at right with salt shaker strapped to her palm.

promptly at noon. At Orange County General Hospital, Orange, Calif., this was a typical Wednesday when patients engage in a weekly excursion into do-it-yourself good eating.

There was a continual buzz of conversation and much good natured banter, a surprising state of affairs from patients who had been suffering from chronic "hospitalitis" and who initially had turned sullen and uncommunicative at the suggestion that they take a turn in the kitchen.

How did this happen? It happened in stages and reached its present level through trial and error.

First, the medical directors of the rehabilitation and physical medicine departments enlisted the help of the dietary department to test a germ of an idea. As an experiment, a dietitian and one patient met in an empty ward kitchen one morning to mix up a gelatin dessert from a packaged mix. The ward kitchen, which could accommodate two wheel chairs at most, was equipped with stove, sink and refrigerator, but no work space. The dessert was a success, the patient shared it with others in her ward, and because of the compliments she received was encouraged to try something a little more complicated the following week.

Weekly cooking sessions continued, sometimes with one patient, sometimes with as many as seven or eight. When there were more than the kitchen could accommodate, the others gathered around a large table in an adjacent lounge area for their food preparation activities.

The maintenance department added cupboards and work space to the ward kitchen to make it as much like a home kitchen as possible. At the suggestion of a utility company kitchen planner, pull-out boards were installed for the convenience of the wheel-chair cooks, and no cupboards were built under the sink so that there would be leg room for this type of patient.

At first, pots, pans and other necessary pieces of equipment were borrowed from the hospital kitchen. This was not always practical because the heavy duty equipment was too large and too heavy for the handicapped cook to lift. As word of the need for home type of utensils spread about the hospital, donations began to trickle in from hospital personnel and volunteer organizations.

When the cooks gained experience and confidence, they progressed from the preparation of single food items to full meals. Soon the adjacent lounge space was converted into a dining area and patients began to compete with each other to see who could arrange the most attractive luncheon table.

Three types of patients were recommended to participate in this therapy.

In the first group were those who had been hospitalized so long that they had lost the will to participate in anything. It was felt that cooking would especially appeal to women, but attendance figures show that the sessions have included about as many men as women — the men regard cooking as a challenging hobby rather than as a familiar chore.

The second type of patients were those who were learning to live with a disability; those eager to return to a small apartment, perhaps, to care for themselves. These patients were housed in a self-help unit, and came to the kitchen to learn skills that would enable them to prepare their own meals at home.

The third group consisted of patients who were scheduled for intensive physical therapy. It was hoped that this change in daily routine of exercises might motivate these patients to work harder to exercise damaged muscles.

During the last year and a half, approximately 100 patients have come to the kitchen. Two have attended 70 weekly cooking sessions. The others have each attended from one to 10 sessions. Some rather dramatic results have been noted.

1. Foremost is that each "took heart," and morale soared as each discovered he was again useful and capable of doing something for himself and for someone else. Several who had been nursing problems because of unpleasant dispositions developed warm, outgoing personalities as they planned and cooked their own meals. They especially enjoyed entertaining doctors and nurses at luncheon — putting themselves on the giving end of things rather than receiving.

2. They bloomed under the compliments of ward mates when they returned to bed with homemade cookies to pass around. Furthermore, they seemed to reason that one who could turn out a creditable lemon meringue pie could do other things and no longer had reason to languish in bed.

3. It became easier for the medical staff to judge how soon a patient was ready for discharge in specific terms of what he could do for himself in regard to housekeeping. A performance test was devised that included a range of activities from "wiping up spills" and "opening packaged goods" to "reaching high cupboards" and "removing hot pans from oven to table."

4. These sessions, which lasted from 9:30 a.m. until 1 p.m., included much exercise. Everyone was willing to beat the cake batter 150 strokes

(Continued on Page 117)

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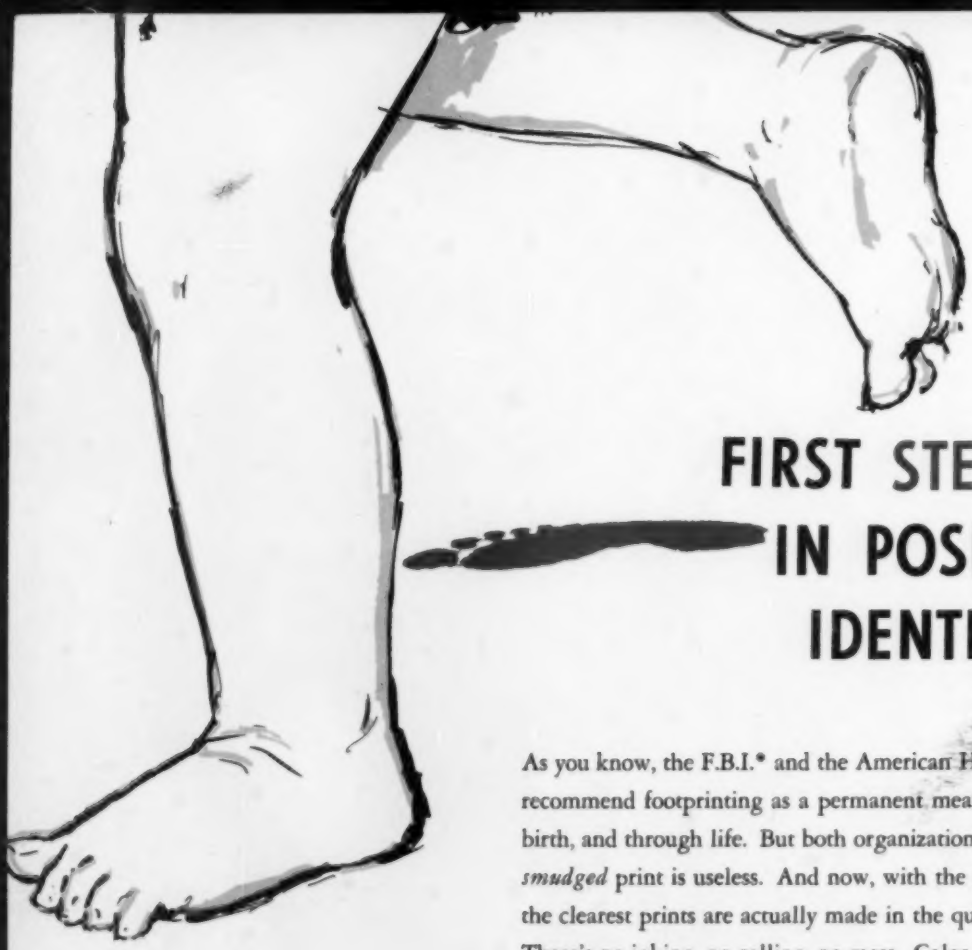

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**Law Enforcement Bulletin, F.B.I., Jan. 1945 and Dec. 1956. *Principles and Recommended Procedure as a Guide for the Identification of the Newborn in Hospitals, A.H.A., Dec. 3, 1949, revised Feb. 7, 1957.*

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(*Continued From Page* 114)
to produce a beautiful layer cake. A tussle with the can opener was won over great odds when it helped toward the achievement of a mouth-watering tamale pie. Nuts were chopped very vigorously indeed in a race to have them done before the fudge got hard.

Obviously, many difficulties were encountered in transporting and supervising handicapped cooks. The program could not have reached its present scope without the help of the hospital's volunteer organization. Under the direction of a dietitian, two or three volunteers take charge of assisting patients to the kitchen, organizing the work to be done, and giving assistance when necessary.

It is their aim to see that the menu items are successful and that a time schedule is followed. Beginning cooks and extremely handicapped cooks need more assistance, naturally, than those with the ability and know-how to go ahead on their own. The dietitian holds a briefing meeting with the volunteers before each session to acquaint them with menu plans and the cooks' general progress and abilities. This appears to be a rewarding part of the volunteer program, since homemakers who want to give their time have skills that lend themselves to patient progress here.

We have not succeeded in interesting either patients or volunteers in dishwashing, so this task is done by the hospital kitchen staff, which also supplies the raw food that is used.

Very little special equipment has had to be purchased by the hospital. Outside groups have donated many things. Especially useful are an electric mixer, an electric frying pan, and an electric stew pot. The last two items can be easily used at card table height by those who cannot reach to stove level.

Linoleum coated lap boards made by the maintenance department come in handy, as does the mirror over the stove that is set to reflect what's cooking. Plastic bowls are light to handle and have the advantage of being unbreakable. Casseroles in a variety of sizes and shapes are used often because oven cookery is the one most convenient for the wheel-chair cook.

Cooks are encouraged to help with menu plans and to contribute to a menu maker — a loose-leaf notebook in which they write suggestions and paste pictures and recipes of dishes they would like to prepare.

Sometimes the cooks collaborate on an elaborate dish, but usually each likes to follow his own complete recipe so that when the compliments come in, there will be no doubt as for whom these are intended.

The newest cook usually prepares coffee and toast for a midmorning coffee break. Four or five other cooks can be kept busy preparing menus.

Other successful projects have been dyeing eggs for Easter trays for the entire hospital, making open-faced sandwiches and cookies for a staff tea, baking fancy Christmas cookies, and preparing box lunches for the cooks to take out of doors to eat picnic fashion.

The most ambitious undertaking was a bid for more volunteers; the cooks (with just a little help from hospital kitchen workers) prepared and served a buffet luncheon for 80 prospective volunteers. This turned out so well that it has been entered on the hospital calendar as an annual event. ■

Thermometer Is Key to Proper Refrigeration

Jane Hartman

REFRIGERATION, certainly, represents a vital phase of dietary department sanitation. Not only do we need to protect the natural quality of meat and perishable foods, but we also are finding increasing use for frozen food products for which suitable refrigeration is essential. Futhermore, basic houskeeping in refrigeration areas is essential.

Jane Hartman

Hospitals require two types of refrigerated storage.

Frozen foods require temperatures of 0 F. or below. Whether they are kept in a reach-in or walk-in freezer depends upon the volume of frozen food products. A reasonable basis for planning this type of refrigeration is the assumption that whatever today's volume of frozen products may be, the future uses will be greater as frozen food technology continues to expand and improve.

In the deep freeze, humidity is not an important factor if foods are well packaged.

The second and more conventional type of refrigeration requires temperatures maintained at 32 F. to 50 F., and high humidity is essential. Humidity range between 65 and 95 per cent will prevent excessive moisture loss and deterioration of food.

Since temperature is the critical factor the need for reliable thermometers in *all* refrigerators cannot be overemphasized. As a matter of fact, a good preventive maintenance program would include the daily charting of thermometer readings of each box.

Reach-in refrigerators and freezers or frozen food cabinets should be equipped with refrigerator-freezer thermometers. This type of thermometer is designed to hook on shelves or partitions or to be placed on flat surfaces within the box. They have a temperature range of at least −40 F. to 60 F. scaled in 2 degree divisions, and a liquid-filled or mercury-filled magnifying glass tube. A frame with scale completely encased to protect the thermometer bulb will help to slow down changes in temperature indications when the refrigerator door is opened.

Walk-in refrigerators and freezers require remote-reading thermometers to permit temperature checking from the outside.

This thermometer has the same temperature range as the thermometer described previously and a liquid-filled magnifying glass tube with 4 feet of capillary tube and a temperature-sensitive bulb attached. An enameled scale should completely encase the bulb for protection, and mounting holes in the metal back are needed. The bulb should be placed inside the regular storage compartment where air can freely circulate.

Modern kitchen planning demands refrigeration conveniently located in relation to both receiving and food preparation areas. There are a number of construction and design features that are important.

Hardware that can be locked, for example, is important. Doors on both sides of the refrigeration area for pass-through installations can add efficiency to some floor plans; wheeled units, glass doors, and portable racks are other options to be considered. Good interior lighting, automatic defrosting, and interiors of stainless steel, aluminum or porcelain are equally acceptable in reach-in boxes.

While most walk-in refrigerators are built as part of the original building contract, sectional, commercial types are available. Vermin-proof insulation on the floors, walls and ceilings will prevent costly repair bills. Massive doors of gleaming stainless metal are popular, but not nearly as important as interior surface materials that clean easily. Glazed tile or stainless metal are by far the best for interior walls. It is essential that the floor not only be durable and easily cleaned, but that it also be flush with the outside flooring to allow easy carting.

When planning refrigeration, it is best to consult state and local building and sanitation codes to assure existing standards are met. A good basic text for every dietitian is "Food Storage Guide for Schools and Institutions," prepared by the U.S. Department of Agriculture, and available for 25 cents from the Government Printing Office.

Remember that refrigeration equipment — while expensive to install — is costly to move. Take your time in planning the layout, select the equipment best suited to the layout, think of the inside as well as the outside appearance factors, and, finally, take care of what you have by good maintenance and housekeeping. ■

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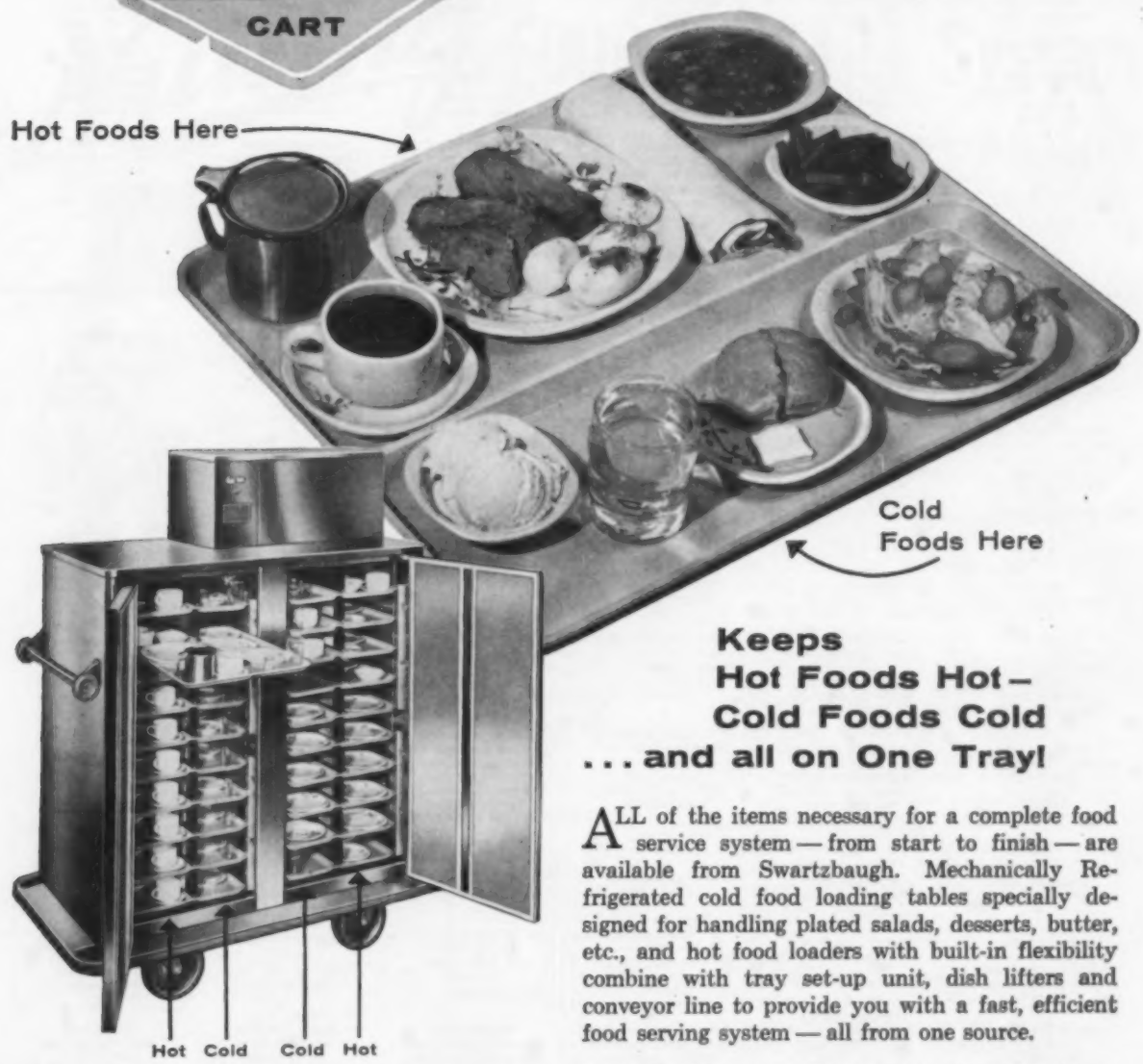

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Menus for September 1961

Catherine Farrow
Therapeutic Dietitian
Lakeland General Hospital
Lakeland, Fla.

1

Peeled Apricots
Scrambled Egg

•

Grapefruit Juice
Fried Fish
Baked Potato
Scalloped Tomatoes
Coleslaw
Ice Cream

•

Mushroom Soup
Cheese Souffle
Lima Beans
Candied Carrots
Citrus Section Salad
Apple Pie

2

Orange Juice
Poached Egg

•

Tomato Juice
Grilled Cube Steak
Buttered Rice
Mixed Vegetables
Tossed Salad
Gelatin

•

Cream of Pea Soup
Chicken-Noodle Casserole
Baked Potato
Brussels Sprouts
Cranberry Salad
Peanut Butter Cookies

3

Peach Nectar
Scrambled Egg

•

Apple Juice
Roast Beef au Jus
Whipped Potatoes
Broccoli, Lemon Sauce
Frozen Fruit Salad
Chocolate Cake

•

Vegetable Soup
Cold Plate:
Sliced Ham, Cheese,
Tomato, Cucumber,
Spiced Peach
Ice Cream

4

Grapefruit Sections
Soft Cooked Egg

•

Apricot Nectar
Roast Lamb, Gravy
Baked Potato
Buttered Carrots
Tossed Salad
Lemon Bisque

•

Chicken Rice Soup
Beef Pot Pie
French Green Beans
Cauliflower, Cheese Sauce
Banana Salad
Date Bar

5

Stewed Prunes
Scrambled Egg

•

Tomato Juice
Roast Veal
Parslied Potatoes
Buttered Beets
Relish Plate
Rice Pudding

•

Beef Noodle Soup
Macaroni and Cheese
With Canadian Bacon
Buttered Asparagus
Sunset Salad
Cupcake

6

Orange Juice
Egg, Sweet Roll

•

Grape Juice
Fried Chicken
Creamed Potatoes
Whole Baby Okra
Fruited Coleslaw
Ice Cream

•

Corn Chowder
Spaghetti and Meat Sauce
Buttered Peas
Shredded Lettuce,
French Dressing
Apple Pie

7

Applesauce
Scrambled Egg

•

Blended Juice
Fried Liver
Buttered Grits
Turnips
Carrot-Raisin Salad
Custard

•

Cream of Potato Soup
Meat Loaf, Creole Sauce
Mashed Potatoes
Wax Beans
Peach-Cream Cheese
Salad
Chocolate Pudding

8

Pear Nectar
Poached Egg

•

Grapefruit Juice
Fried Fish, Tartare Sauce
Rice
Buttered Asparagus
Tossed Salad
Gelatin

•

Clam Chowder
Salmon Croquettes,
Egg Sauce
Mixed Vegetables
Fruit Salad
Gingerbread

9

Banana
Sausage, Muffin

•

Vegetable Juice
Veal Stew
Tiny Whole Beets
Asparagus and Sliced
Egg Salad
Blackbottom Pie

•

Tomato With Rice Soup
Salisbury Steak
Black-Eyed Peas
Steamed Green Cabbage
Stuffed Celery
Baked Apple

10

Citrus Sections
Pancakes, Bacon

•

Pineapple Juice
Baked Ham
Baked Sweet Potato
Chopped Spinach
Spiced Peach Salad
Ice Cream

•

Beef Noodle Soup
Chicken Pie
Glazed Carrots
Tomato and Lettuce,
Roquefort Dressing
Cherry Cobbler

11

Whole Apricots
Poached Egg

•

Grapefruit Juice
Roast Beef
Rice and Gravy
Brussels Sprouts
Lettuce Salad, Oil and
Vinegar
Grapenut Custard

•

Chicken Noodle Soup
Stuffed Pork Chop
Yellow Squash
Waldorf Salad
Coconut Cake

12

Concord Grapes
Fried Egg

•

Apple Juice
Broiled Chicken
Mashed Potatoes
Whole Baby Okra
Relish Plate
Dutch Apple Pie

•

Cream of Mushroom Soup
Meat Loaf, Tomato Sauce
Buttered Cauliflower
Italian Green Beans
Citrus Section Salad
Gelatin, Custard Sauce

13

Banana
Scrambled Egg, Bacon

•

Tomato Juice
Lamb Chop
Sweet Potato Casserole
Turnip Greens
Waldorf Salad
Cottage Cheese Cake

•

Vegetable Soup
Hot Roast Beef Sandwich
English Peas
Tossed Salad
Ambrosia

14

Pineapple Juice
Soft Cooked Egg

•

Grape Juice
Broiled Chicken Livers
Baked Potato
Buttered Broccoli
Carrot-Raisin Salad
Ice Cream

•

Cream of Chicken Soup
Ham Salad Sandwich
Pickled Beet Salad
Banana Pudding,
Sugar Cookie

15

Half Grapefruit
Scrambled Egg

•

Broiled Spanish Mackerel
au Gratin Potatoes
Buttered String Beans
Coleslaw
Lemon Pie

•

Tomato Bouillon
Tuna-Rice Casserole
Julienne Carrots
Tossed Salad
1000 Island Dressing
Cherry Cobbler

16

Stewed Prunes
Poached Egg

•

Pink Lemonade
Roast Lamb, Gravy
Mashed Potatoes
Buttered Spinach
Tossed Salad
Peach Shortcake

•

Beef-Vegetable Soup
Ham and Asparagus Roll
With Cheese Sauce
Black-Eyed Peas
Mixed Fruit Salad
Tapioca Pudding

17

Applesauce
Sweet Roll

•

Peach Nectar
Roast Turkey, Dressing
Cranberry Sauce
Buttered Rice
Celery and Peas
Pear Salad
Brownie

•

Celery Soup
Braised Beef, Noodles
Mustard Greens
Relish Plate
Sherbet

18

Fresh Plums
Fried Egg

•

Hawaiian Punch
Grilled Pork Chop
Candied Yams
Buttered Asparagus
Spiced Apple Rings
Butterscotch Pudding

•

Cream of Pea Soup
Chicken a la King on
Toast Points
Buttered Carrots
Cranberry Salad
Sugar Cookie

19

Grapefruit Juice
Waffle, Sirup

•

Grape Juice
Beef Pot Pie
Green Beans
Apricot With Cream
Cheese and Nuts
Coconut Cake

•

Cream of Asparagus Soup
Fried Chicken
Buttered Grits
Succotash
Perfection Salad
Fruit Cup

20

Pineapple Juice
Pancakes, Sausage

•

Limeade
Stuffed Green Pepper
Yellow Squash
Lettuce Salad
Jelly Roll

•

Tomato Bouillon
Tuna Salad Sandwich
Parslied Potatoes
Green Peas
Pineapple-Cottage
Cheese Salad
Custard

21

Banana
Fried Egg

•

Vegetable Juice
Fried Liver
Harvard Beets
Asparagus Tips
Celery Hearts, Olives,
Pickles
Peach Crisp

•

Cream of Chicken Soup
Grilled Hamburger Patty
O'Brien Potatoes
Buttered Spinach
Fruit Salad
Boston Cream Pie

22

Pineapple Juice
Scrambled Eggs

•

Grape Juice
Shrimp Creole
Cut String Beans
Pear Salad
Sherbet

•

Vegetable Juice
Creamed Eggs on Toast
Buttered Green Peas
Waldorf Salad
Gelatin With
Whipped Cream

23

Kádota Figs
Poached Egg, Bacon

•

Orange Juice
Roast Beef Sandwich
Broccoli
Lettuce Wedge Salad
Lemon Snow Pudding

•

Potato Soup
Glazed Ham With
Pineapple Slice
Baked Potato
Buttered Asparagus
Celery and Carrots
Sugar Cookies

24

Sliced Peaches
Sweet Roll

•

Pineapple Juice
Pork and Yellow Rice
Brussels Sprouts
Tomato Salad
Ambrosia

•

Celery Soup
Hamburger on Bun,
Onion Slice
French Fried Potatoes
Relish Plate
Chocolate Cake

25

Poached Egg
Sweet Roll

•

Limeade
Creamed Chipped Beef
on Mashed Potatoes
Buttered Carrots
Coleslaw
Canned Pear

•

Tomato Soup
Broiled Chicken
Scalloped Corn
French Style Green Beans
Banana Salad
Ice Cream

26

Pineapple Juice
Waffle, Sirup

•

Blended Juice
Chicken Chop Suey
Brussels Sprouts
Frozen Fruit Salad
Iced Cupcake

•

Cream of Chicken Soup
Roast Veal
Baby Limas
Buttered Beets
Tossed Salad,
Oil and Vinegar
Applesauce

27

Fresh Plums
Soft Cooked Egg

•

Peach Nectar
Salisbury Steak
Rutabagas
Buttered Spinach
Stuffed Celery
Date Bar

•

Beef Noodle Soup
Fried Liver and Onions
Mashed Potatoes
Turnip Greens
Pineapple-Cottage Cheese
Salad
Chocolate Pie

28

Pineapple Juice
Scrambled Egg

•

Apricot Nectar
Roast Beef
Mashed Potatoes
Broiled Tomato
Lettuce Salad
Prune Cake

•

Cream of Chicken Soup
Breaded Veal Cutlet
Rice
Harvard Beets
Asparagus Salad
Royal Anne Cherries

29

Citrus Sections
Poached Egg, Bacon

•

Broiled Red Snapper,
Tartare Sauce
Boiled Potato
Green Beans
Coleslaw
Lemon Pudding

•

Vegetable Soup
Egg Salad Sandwich
Buttered Asparagus
Stewed Tomato and
Eggplant
Peach Salad
Sherbet

30

Applesauce
Pancakes, Bacon

•

Orange Juice
Roast Pork
Corn on the Cob
Tiny Whole Beets
Spiced Apple Salad
Sherbet

•

Celery Soup
Corned Beef and Cabbage
Black-Eyed Peas
Fruit Salad
Chocolate Chip Cookies

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hospital food service

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ends "DIET TRAY CONFUSION!"

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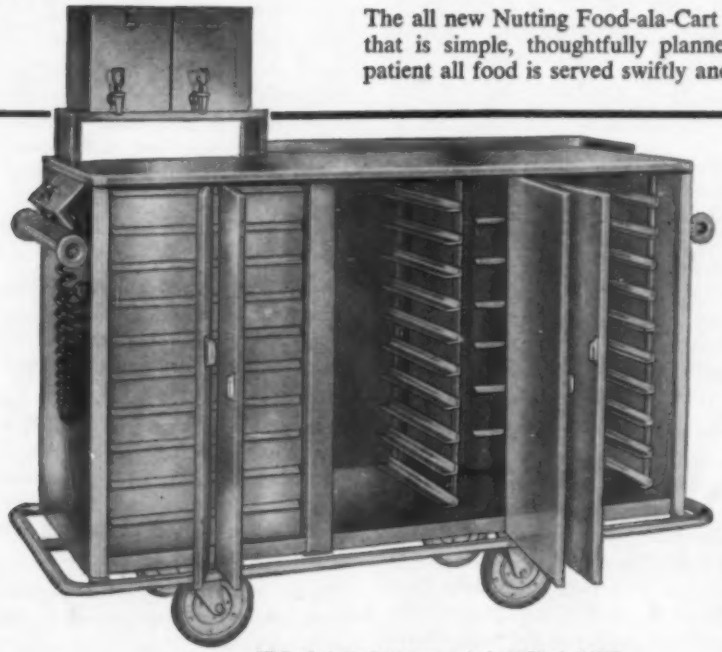

Food-ala-Cart ends diet tray confusion because there is only **one** serving per oven drawer and this matches its own serving tray . . . there's absolutely **no chance** of mix-up or confusion!

Food-ala-Cart also improves the appetite appeal of food because it has three separate temperature zones ranging from "piping hot" to "cold" to "deep freeze." All foods reach patients at the peak of flavor and nutrition and at dietetically approved serving temperatures.

Your hospital food service system will function more smoothly with Nutting Food-ala-Cart on the job. This equipment is the "key" that unlocks the door to well-balanced food service and makes everyone, from the dietitian to the patient to the physician, happier and more satisfied with food preparation and service. Write today for complete facts about this newest idea to streamline your hospital food service.

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HOT COLD
THE WELL BALANCED FOOD SERVICE SYSTEM

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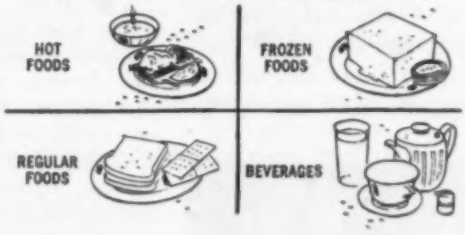

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Nutting Truck & Caster Co.
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How To Plan Space for Sanitation Storage

Raymond Q. Duke

SANITATION storage facilities are often overlooked in planning an efficient maintenance system. But they're far too important to ignore or treat lightly.

If properly designed and used, these facilities can reduce nonproductive time, increase output and efficiency, and contribute to employe satisfaction and morale, thus combating manpower turnover.

The first step in an improved program should be the installation of proper facilities from which workers can be issued equipment and supplies for their daily assignments.

Industry has proved that centralized storage and disbursing facilities are economical and efficient. They make it possible to reduce inventories and provide a continuous check on the consumption of expendable supplies and the need for employe retraining or methods improvement.

The central storeroom is essentially one large room in which all types of supplies are kept to equip and dispatch maintenance and housekeeping personnel. It must handle a great variety of materials and considerable quantities of some materials. This type of storeroom is applicable to a building up to 50,000 square feet.

In larger buildings there is justification for dividing the central storeroom according to the division of the operating organization. One variation, applicable to buildings up to 300,000 square feet, would have two central storerooms, one for the housekeeping group and one for the "maintenance" group, which handles all mechanical and construction matters. When the building or area of responsibility is greater than 300,000 square feet the central storeroom idea can be further varied to provide facilities for each of the work groups.

About 20 per cent of the total area allocated for the sanitation facilities should be set aside for the active supply room. From here routine and periodic maintenance crews are dispatched by means of the work assignment board or chart. It should have sufficient open shelf storage space for a one-week supply of the tools, cleaners, waxes and other items in daily use. It also serves as a depot for the exchange of uniforms and tools.

The room should be functional in layout, designed for efficient dispensing to reduce waiting and nonproductive time. A great aid to efficiency is a dispensing bar for liquid and powder supplies.

Convenient cabinet is large enough to store equipment and supplies used in area, yet it requires little space.

Few large buildings can afford to assign machine equipment to each floor and the installation of modern cleaning programs is diminishing the need for this. Therefore, a central storage area should be provided for buffing machines, wet and dry vacuums, large machine scrubbers, and such equipment.

About 5 per cent of the total maintenance area will be required for machine storage. Equipment should be grouped by type and readily accessible for inspection and withdrawal. Brushes and special tools are best stored on wall-mounted pegs. A small-parts locker is advisable for minor machine repairs.

From 25 to 35 per cent (depending on the stock level period) of the maintenance area will be required for the storage of bulk, drum and case lot supplies.

Also stored in this area would be the surplus or reserve tools and equipment, and the myriad of seasonal and special occasion items which are handed down to the plant engineer for storage.

There are four other functions which might be incorporated in the central storage designs:

1. With the increasing popularity of the mass lamp changing technic and its consolidation with lighting fixture cleaning, these operations are often assigned to special crews. An area should be set aside for the storage of replacement lamps, fixture washing equipment, ladders and mass-changing supplies.

2. Because janitor training is a continuing responsibility of supervision, it is advisable to incorporate a training room in the central facilities of the department.

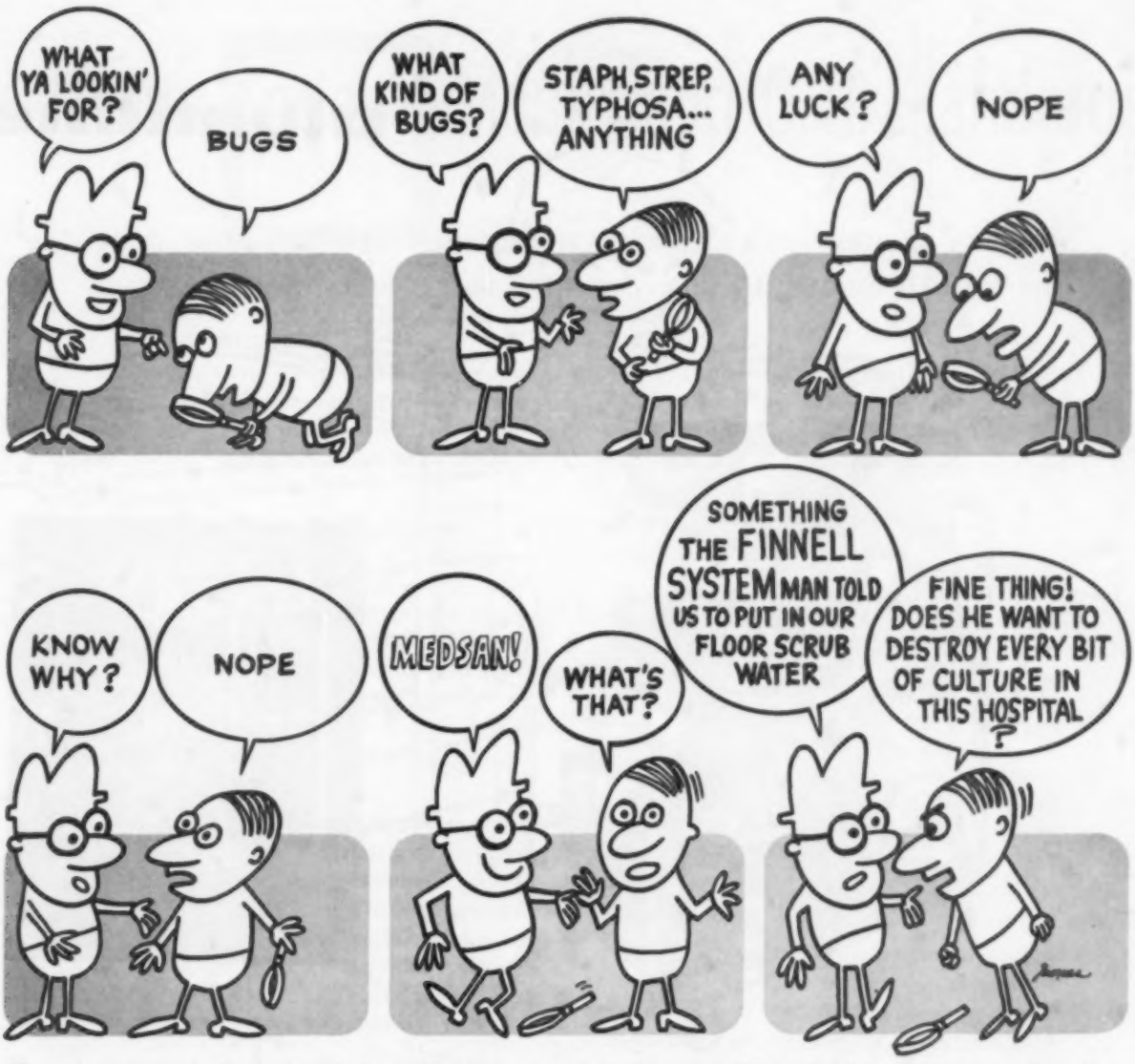
3. In those buildings that house restaurant facilities, space must be allocated for garbage can washing and storage facilities. The value of this space and the cost of washing facilities must be weighed against the installation of kitchen garbage disposal units or incineration.

4. Building location, lobby design, and management preference may per-

(*Continued on Page* 126)

Mr. Duke is operations supervisor of the buildings and properties department, the Detroit Edison Company, Detroit, and is president of the Institute of Sanitation Management, New York.

This article is adapted from a paper presented at the 3d Industrial and Building Sanitation Maintenance Conference, New York.



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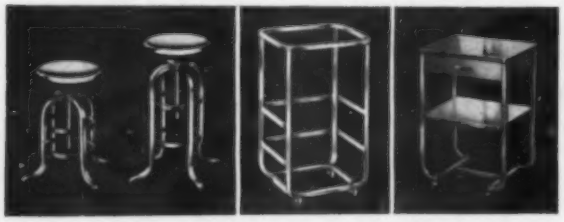

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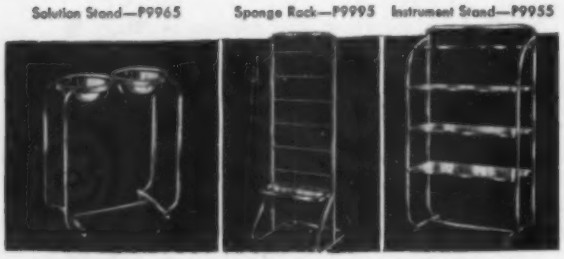

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(*Continued From Page* 122)
mit the storage of lobby entrance matting during fair weather. Depending upon the number and location of the entrances, mat storage may be feasible in the central storeroom.

Cleaning time can perhaps best be saved by lessening the time required to get equipment and materials assembled at the work site and in returning them at quitting time.

At the beginning of the shift a crowd assembles at the dispatching point. There is a wait as each man draws his tools and materials. Then there is the social period while waiting for the last man to get his supplies so they can all ride up on the same elevator. Near the end of the shift there begins the long return trip with the floor-by-floor stop-off to pick up others in the crew. Some janitors exercise initiative to conserve at least some of the effort, if not the lost time, by leaving certain pieces of equipment and materials in strategic corners in their area. Unfortunately, these corners soon take on the appearance of junk piles.

Another nonproductive delay occurs during the work period when an unexpected depletion of supplies, an emergency change in work assignment, or a tool replacement necessitates a trip to the stockroom. This is certainly a valid excuse for a janitor leaving his work area and it is natural if he makes several stops en route in an effort to borrow the needed item from some other janitor. A conservative estimate of time lost on these emergency trips is 20 minutes per incident. In an 80 man work force one such incident per worker per week would result in a full man's time lost each week.

The best answer is the installation of small, on-the-job supply rooms, called area custodial closets or field stations. If these are strategically located, transportation time is minimized and production increases.

About 40 per cent of the total sanitation area should be allocated to these closets. In other terms, about one square foot of closet area should be provided for each 500 square feet of floor area maintained, with a minimum size of 25 square feet. In buildings with long, narrow floor areas it is advisable to install several closets per floor so that the farthest distance from any one closet is no more than 300 feet.

The minimum width or depth dimension of this closet should be 4 feet and the minimum ceiling height 8 feet. The walls, or at least a 60 inch wainscot, should be of salt-glazed brick, ceramic or plastic tile. The floor should be of hard tile or terrazzo. The lighting intensity should be a minimum of 40 footcandles, preferably fluorescent. Guards on all lighting fixtures will protect them from mop handles and ladders. A means of positive ventilation should be installed to provide from 15 to 20 air changes per hour to ensure adequate mop drying and odor elimination. The door should be equipped with a self-closing device, a foot-operated stop, and a rigidly controlled lock. The bottom one-third of the door should have an intake air louver for a maximum of 300 feet per minute air velocity.

In the far end of the closet, or aside from the main traffic aisle from the door, should be an in-the-floor slop sink, its protected rim extending not more than 6 inches above the floor. A wall-mounted mixer faucet should be installed no less than 36 inches above the sink rim. Attached to the faucet should be a length of flexible hose sufficiently long to reach the sink rim. This hose will necessitate, under most municipal plumbing codes, an antisiphon device on the water supply piping. The space to either side of the slop sink can be utilized for on-the-floor storage of pails.

Above the slop sink, and at least 5 feet from the floor, should be the supply shelving. There should be a minimum of 10 square feet of shelf space with a minimum of 18 inches between shelves to accommodate the wide variety of supplies. The hand duster frame, dustpan, counter brush, commode brush, and lint brush should be suspended from hooks on the under side of the bottom shelf. From a wall rack equipped with cam action tool holders should hang the wet mops, swivel dust mops, push brooms, and other long-handled tools. This should leave sufficient floor space for the storage of the wastepaper collection cart and other portable equipment.

The area cabinet is an alternative, if funds or space are not available for the installation of closets. These are two-section, built-up cabinets providing compact storage space for all the supplies, tools and equipment required by the area served. Built-in sinks and mop wringers, with hot and cold water, can make the cabinets almost as flexible as a closet.

Using a conservative figure of $30 per square foot to install the features outlined for an area custodial closet, and fixed charges of 9 per cent, the minimum area closet can be paid for by a reduction of 9 minutes per day in the nonproductive time of the janitor using this closet. Again, using the average figure of $15 per square foot for general building modernization work, total sanitation area requirements can be paid for by reducing nonproductive time by 48 minutes per year for each square foot required. ■

How To Determine Space Requirements

SUGGESTED standards for storage space requirements were developed in six large Detroit area buildings, both office and industrial. In formulating these standards, I enumerated the facilities now assigned to each sanitation engineer and the space he would like to have, considering his area of responsibility, the supplies stocked, and the size of the work force.

The table was not difficult to draft because the ratio of space need to space maintained was about the same in each property. It will, of course, be necessary for many other buildings to test this table before it can be recommended as a standard. Here is the table:

Building Area Maintained	Total Space Required for Sanitation Storage
Up to 50,000 sq. ft.	1 per cent of area maintained
From 50,000 to 300,000 sq. ft.	¾ of 1 per cent of area maintained
Over 300,000 sq. ft.	½ of 1 per cent of area maintained

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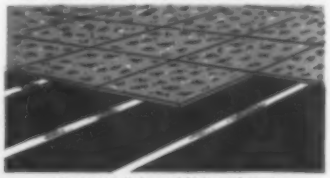
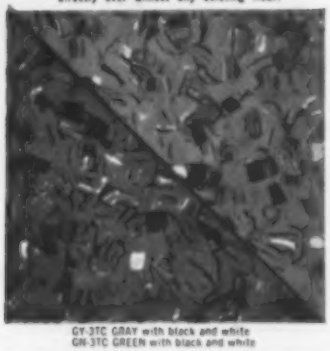


Can be installed overnight in most cases, directly over almost any existing floor.



GY-3TC GRAY with black and white
GR-3TC GREEN with black and white

W-3TC WHITE with black
BK-3TC BLACK with white

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How To Keep Personnel Relations Personal

Continuing the series of lectures on

Administrative Housekeeping for Institutions

Mildred L. Chase

QUALIFICATIONS of the executive housekeeper include a knowledge of the mechanics of the department. More important is the "humanics" of the department. The functions of administrative work must be achieved through people. The human element of administration can properly be called the "humanics" of administration.

Humanics

Humanics stress such aspects as:

Morale
Leadership
Group dynamics

Emphasis

Emphasis should be upon practices or applications of our knowledge of human relations — not upon theory or research.

1. There is no single magic technic that can be applied to all situations that may arise.

Humanity yearns for certainty, sets of rules, plans, technics.

Few, if any, rules of behavior or technics apply to all.

For every principle discovered, there is almost certainly a conflicting principle.

2. Both individuals and situations differ:

A successful technic in one situation might be catastrophic in another circumstance.

The spirit in which technics are applied is more fundamental.

If motives are unsound, no technic is good.

Power

Power over people — flattery:

Manipulating people.

Bag of tricks to influence or handle people is autocracy covered with a veneer of hyprocrisy and is superficial and dangerous.

Praise

Power gained through and with people:

Is a sound philosophy of management.

Is sincere recognition of effort.

Is solid and enduring.

Demonstrates love of, respect for, and confidence in people.

(*Continued on Page* 130)

TEN COMMANDMENTS OF GOOD PERSONNEL RELATIONS

1. Give the employe the facts; keep him in the know in advance.
2. Do not dominate the employe; allow him his self-respect.
3. Promote a competitive spirit among employes but avoid a fight.
4. Set an example for the employes; they like to respect their superiors. Train supervisors in good personnel relations.
5. Consider the employe's sentiments and social situation.
6. Make the worker feel important; appeal to his mastery drive. Give him an opportunity not only for advancement, but also for expression.
7. Provide reasonable security and safe, healthful working conditions.
8. Be firm. Do not give concessions too easily; let the employe feel he has earned them.
9. Treat each employe as an individual; d e t e r m i n e what makes him a valuable employe.
10. Make decisions as fairly as possible after considering the facts. Be especially careful to be objective in making decisions.

This is the first of two sections on Principles of Personnel Administration in Mrs. Chase's course on "Administrative Housekeeping for Institutions." The second section will appear next month. This series of lectures was started in the May issue of The Modern Hospital. The lectures are presented as topical outlines so the lecturer can adapt the materials to the needs of the class.

Mrs. Chase is director of housekeeping services, Glendale Sanitarium and Hospital, Glendale, Calif., and director of the housekeeping course at Los Angeles Metropolitan College of Business.

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THIS QUESTIONNAIRE HELPS SUPERVISOR APPRAISE EMPLOYES

Job Performance

How does the employe rate with respect to:
1. Quantity of work?
2. Quality of work (mistakes, errors, spoiled work, and other defects)?

Does he carry out orders as directed? On time?
How well does he take care of:
1. Equipment?
2. Work place?

Does he make constructive suggestions?
Does he sit around waiting for work or keep other employes from doing their work?

Personal Traits and Capacity

What are his strong points?
What are his primary weaknesses?
Is he cooperative?
Does he get along well with his fellow employes and his superiors?
If not, why not?
Is he ambitious? If so, should he be encouraged to get ready for a better job?

Possible Action To Be Taken

Does he need additional training? If so, what kind?
Does he deserve a merit increase?
Should he be transferred?
Is he ready for promotion? To what job?
Is there any other action that should be taken in regard to him?

Housekeeping

(*Continued From Page* 128)

Guides to behavior:

Behavior is generally directed toward satisfaction of certain fundamental needs.

Leadership must bring satisfaction of certain fundamental needs.

1. All yearn for participation: Like to play a real part in the organization. Like to participate in determining policy. Like to help make decisions that affect them. Place responsibility and authority as close to the source of action as possible.

2. All have an urge for recognition and approval. Give a man's work a character of uselessness and it will reduce a man to nothing. Praise must be sincere. One of the deepest feelings in human nature is the craving to be appreciated.

3. All seek a sense of belonging. A fierce group loyalty will keep morale high. Each employe should be made to feel that he is an important part of the group.

4. All yearn for fair treatment by superiors. This has highest rating on list of job satisfactions. Should always be constructive criticism without fear of reprisal. Loyal opposition should be respected and protected. Employes should not be criticized until they have a chance to state their own case. Employes should not be criticized publicly. Employes should not be fired until they have been given a hearing. Employes should be given help aimed toward improvement.

5. All like a happy work climate. Give as much attention as possible to complaints, both major and minor.

Use "suggestionnaires" eliciting suggestions for improvement. It helps if people can have their say even if they cannot have their way. Job descriptions stating responsibilities will help clarify employes' thinking.

6. All are searching for security. In jobs as well as in life. This is the broadest and most basic of all needs. Want security against unfair criticism. Security against arbitrary criticism. Security against unfair dismissals. Security against unjust promotion policies. Security against sudden and unexplained change.

7. Administration should be devoted to the processes of rational inquiry. People have the right to pursue public problems. People have the right to examine public data. Technics that depend upon secrecy for success generally fail. Information about individuals should be treated confidentially. The line of communications should be kept open in both directions. Technics should be geared for free trade in both ideas and information. The lack of information tends to fill the vacuum with rumor. The truth, no matter how bad, is better than no information at all. Encourage the exploration of controversial issues. Should be dedicated to the preservation of our basic freedom – the pursuit of truth.

8. Encourage a fundamental respect for individuality. Strength can be built on diversity rather than on conformity of people.

Remember "personnel is people." Our business is "personnel." In broad terms our business is to select (sometimes recruit), place and serve the people who are employes in our department.

We must assist employes with their work problems.

We must assist employes with their life problems.

We must keep their records in the department.

We must counsel with them as needed.

We must orient new employes.

At times we must conduct termination interviews.

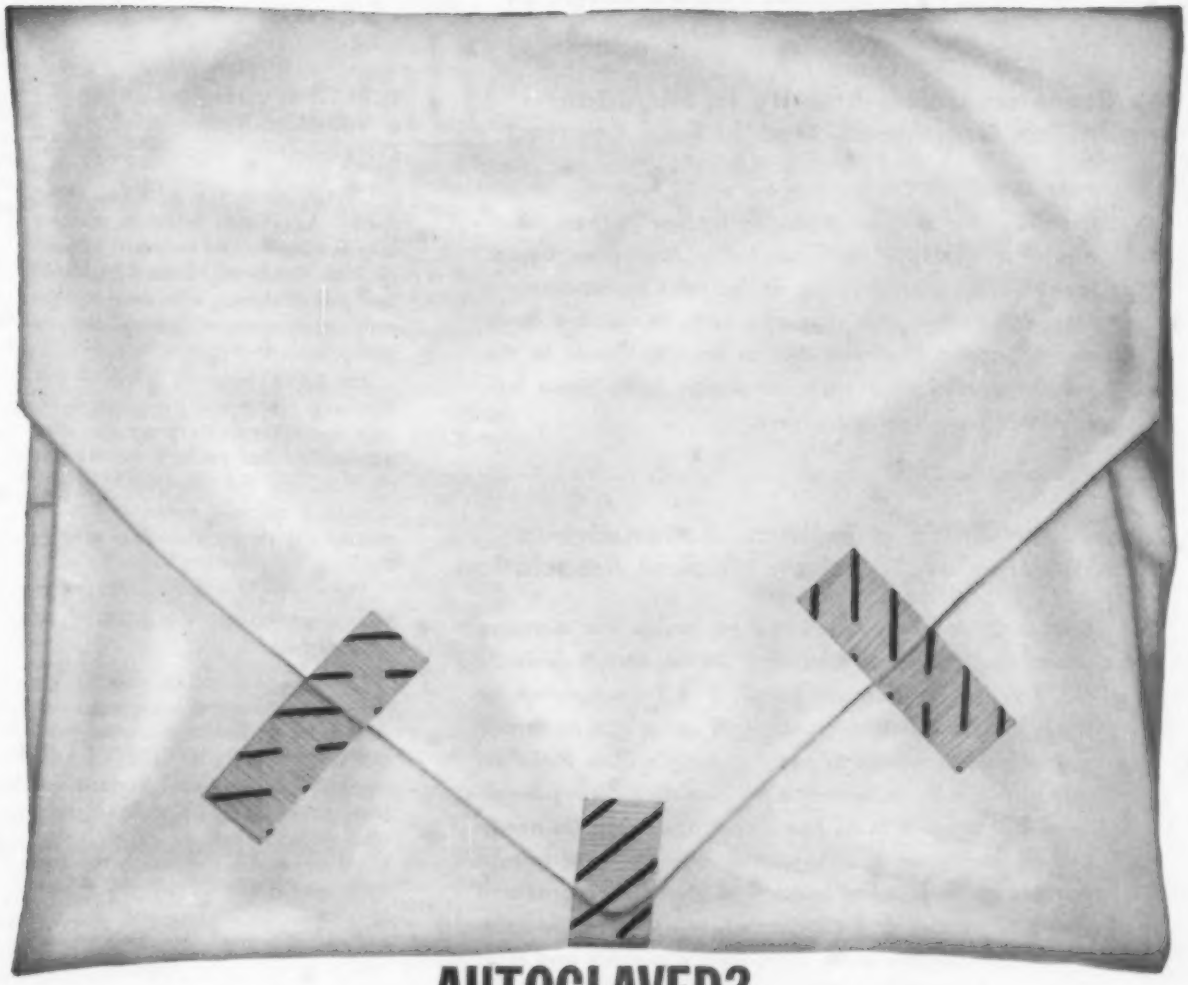
We must act as liaison between employes and administration.

We are responsible for personnel buildup.

We should have a planned program for closer contact with employes.

Scheduled training can bring you close.

Letters and bulletins can prove a potent means of developing employe enthusiasm and a spirit of cooperation. ■



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The Modern Hospital News Digest

Box Score on Union Activity in Michigan: One in Ten Organized, One in Four Courted

ANN ARBOR, MICH. — One out of 10 hospitals in this state is unionized, according to Hyman Parker, hearings officer of the Michigan Labor Mediation Board. Speaking at a conference of hospital administrators here, Mr. Parker said that a recently completed study also indicated that one out of four hospitals in the state reported that their employes have been approached by union organizers. ■

Doctors Organize a Political Action Group With Blessing of American Medical Association

CHICAGO. — A political action group for doctors, called the American Medical Political Action committee, has been organized here. Strongly supported by the American Medical Association, which as a nonprofit group cannot engage in political activity, the A.M.P.A. committee will be financed by donations from members and from A.M.A. The committee, said its newly named chairman, Dr. Gunnar Gundersen, will inform doctors about political issues and give the records and views of parties and candidates. It will also, he said, encourage doctors to be more active in state and local government. The committee, he pointed out, will function independently of A.M.A. ■

"Differences of Opinion" With Illinois Welfare Director Cause Resignation of Assistant

SPRINGFIELD, ILL. — Herbert M. Lowry, assistant director of the Illinois State Department of Public Welfare, resigned under pressure last month as a result of "differences of opinion" with the director, Dr. Francis P. Gerty. While serving as acting director when Dr. Gerty was ill, according to the Chicago Sun-Times bureau here, Mr. Lowry sent dismissal notices to 21 employes of the East Moline State Hospital. It was also revealed that he had prepared a memorandum opposing the requirement set by Gov. Otto Kerner that an experienced psychiatrist should head the public welfare department. ■

A.M.A. Wants To Create a 'Medical Monopoly,' Osteopathic Group Says

CHICAGO. — The American Osteopathic Association flexed its muscles here last month and prepared to take on the American Medical Association and all comers who want to "absorb, amalgamate or destroy" the organization.

The A.O.A. house of delegates was especially distressed over recent efforts in California to merge the state osteopathic and medical associations by dissolving the osteopathic group, a move it officially denounced as an attempt "to create a medical monopoly."

The new A.M.A. position in regard to osteopaths was also attacked by the A.O.A.

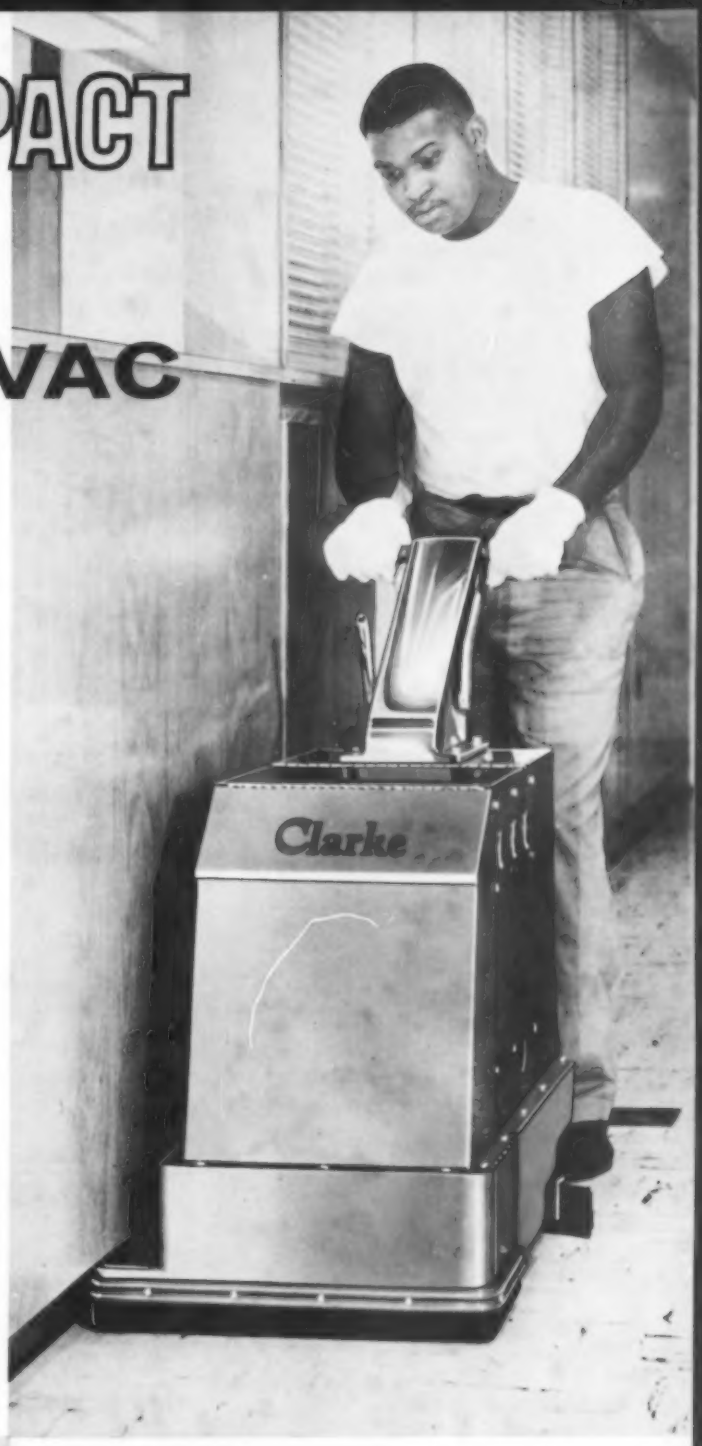
Under A.M.A. policy approved in June, state medical groups decide whether individual osteopaths practice what the A.M.A. calls "scientific medicine" or "cultism." For the first time, osteopaths who practice scientific medicine are, in effect, recognized by A.M.A., although the barriers against cultists are still rigidly in place.

By following this policy, the A.O.A. noted, "The American Medical Association displays not only its general ignorance of the osteopathic school of medicine but confusion between the science and practice of all medicine.

"While it is certainly appropriate for the A.M.A. to 'reappraise its application of policy regarding relationships with doctors of osteopathy,'" the A.O.A. statement continued, "it would be equally appropriate for the A.M.A. to examine carefully, for the first time, the realities of osteopathic theory and practice."

In an effort to nullify what an A.O.A. official described as "divide and conquer tactics by organized medicine," the A.O.A. house of delegates approved a $75 dues assessment to members. The assessment, he said, will bring in an estimated $500,000, which will be used to combat attempts by organized medicine to absorb A.O.A. members.

NEW COMPACT ClarkeAmatic SCRUBBER-VAC



Gives big-machine performance and savings—yet it's priced under $835.00

Now floor maintenance costs can be cut in half in every building with up to approximately 20,000 sq. ft. of scrubbable area.

Heretofore, automatic combination scrubber-vacs (with scrubbing and solution pickup in one unit) have been too large and the investment too costly to warrant use on small and medium size areas.

Now, however, through the development of a revolutionary orbital scrubbing head, Clarke—for the first time in the history of the floor machine industry—has achieved what administrators and maintenance men have sought for years.

It is the Clarke-A-matic Compact Scrubber-Vac. This unique machine gives the same thorough, automatic cleaning and the same cost reductions as larger combination units. *And it is priced way below them.* In fact, it costs little more than an average size floor maintainer and wet-dry vacuum cleaner.

With it, one operator can clean a floor two to four times faster than two men with conventional equipment—and four to six times faster than hand scrubbing.

And it does a complete cleaning job—gets floors Clarke-clean

- Automatically meters easily adjustable flow of cleaning solution.
- Scrubs with revolutionary 3400 times per minute orbital-action scrubbing head equipped with easily replaceable, inexpensive nylon scrubbing pad. High speed movement of pad thoroughly agitates solution to loosen and float dirt.
- Picks up dirt and solution with powerful vacuum. Squeegee dries floor, leaves it sparkling and sanitary.
- Cleans 18" swath and scrubs at speeds from 3,500 to 6,000 sq. ft. per hour to cut cleaning time and slash labor costs.
- Operates with noiseless, odorless battery power. Has no cable to restrict operation. Maneuvers easily, even in tight, congested areas.
- Provides a just-right-size automatic, mechanized floor care unit for average size floor areas—open—or congested—up to approximately 20,000 sq. ft. Perfect for all types of floors, including vinyl and rubber tile, linoleum, wood, asphalt, cork, terrazzo, ceramic tile, etc.
- And the price is surprisingly low—complete with batteries and charger—and ready to go to work on your floors—for under $835!

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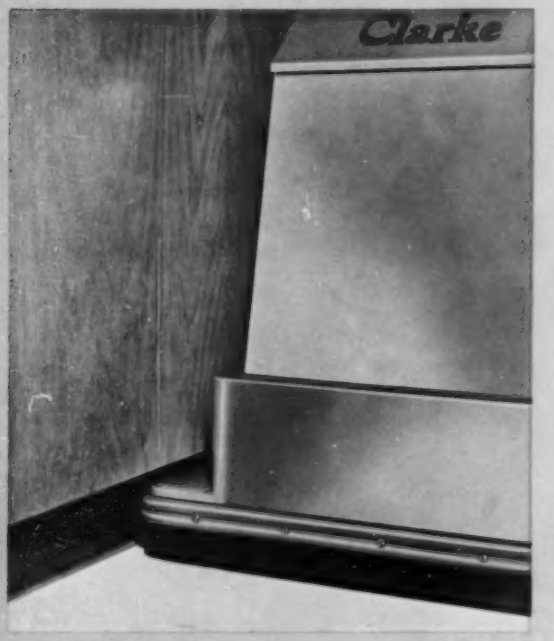
Clarke-A-matic Compact is furnished complete with batteries, scrubbing pad and charger. Wrap-around vinyl bumper protects walls and furniture.



Cleans right up to walls, even gets under toe-space of counters and desks. When scrub head is lowered into operating position, projection at right of machine easily fits under toe-space.

PERFORMANCE DATA AND SPECIFICATIONS

FRAME—Cadmium plated steel, resists rust and corrosion.

OPERATING SPEED—Approximately 120-132 lineal feet per minute.

SCRUB HEAD MOTOR—¾ h.p., 24 volt, ball bearing, D.C., General Electric. Draws 8 amperes.

VACUUM MOTOR—Constant duty, by-pass, moisture-proof, rubber mounted. Drives 2-stage turbine. Quiet in operation and provides 60" water lift with closed orifice. Draws 16 amperes.

BATTERIES—2-12 volt, 100 ampere hours (4 hours machine operation).

BATTERY COMPARTMENT—Enclosed. Treated to resist rust and acid.

SOLUTION TANK—14 gauge steel, rust proofed with baked on epoxy resin finish inside and outside. 5 gallon capacity.

VACUUM TANK—6½ gallon recovery capacity, 14 gauge steel, rust proofed with baked on epoxy resin finish inside and outside. Tank easily and quickly emptied through dump valve.

SQUEEGEE—Over-all width 20". Choice of neoprene oil resistant or natural gum rubber, spring loaded squeegee is lowered or raised by lever control handle which automatically operates vacuum pick-up motor.

SCRUBBING PAD HEAD—5" x 18". Nylon type. Orbital speed of scrub head is 3400 times per minute.

SCRUBBING SPEED—3,500 to 6,000 sq. ft. per hour.

SCRUBBING HEAD PRESSURE—40 lbs.

FRAME WHEELS—5" diameter x 1½" face, non-marking plastic tires.

CASTER WHEELS—4" diameter x 1¼" face, non-marking, mounted on ball bearing swivel bracket.

BUMPER—Non-marking Vinyl.

CLEAN-OUT—Tank emptied through dump valve. Tank cleaned through large door which locks in place with positive action.

CHARGER—Fully automatic, 15 ampere capacity maximum. Charging tapers to low trickle rate as charging is complete (Charger included with machine).

WEIGHT—Net—360 lbs. (without batteries 214 lbs.) Battery weight—73 lbs. each.

SIZE:—Width ..... 22¼"
Length ..... 39"
Height ..... 38¼"
Height from floor to top of scrub head housing .... 3¼"

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New York Medical College, Hotel Council Sign Pact for Family Medical Care

NEW YORK. — Comprehensive medical care for employes of the hotel industry and their families will be provided under a hospital-union fund agreement that was signed here recently.

The five-year agreement, which is expected to set a pattern for future group care programs, will provide for home, office and hospital medical care. It was signed by representatives of New York Medical College-Flower and Fifth Avenue Hospitals, and the New York Hotel Trades Council (A.F.L.-C.I.O.) and the Hotel Association of New York City.

The program will be financed by the Union Family Medical Fund of the Hotel Industry of New York City, a joint labor-management body. Initial outlay is $29,000 for the 9000 employes and dependents now covered. Eventually it is expected that a citywide program will cover 80,000 persons.

Dr. Ralph E. Snyder, president and dean of the medical college, said that this family medical plan offers a realistic, effective alternative to governmental intervention in medical care.

Jay Rubin, president of the New York Hotel Trades Council, called the program "a forerunner of coming developments in . . . medical care."

Texas Medical Association Opposes A.H.A. Proposal for Generic Prescribing

GALVESTON, TEX. — Opposition to the American Hospital Association proposal that hospitals "demand" generic name prescription of drugs has been formally registered by the Texas Medical Association.

In a resolution passed by its house of delegates, T.M.A. voted to oppose "any method by which physicians would be compelled to prescribe drugs by generic name only."

The resolutuion asserted that "the compulsory procedure would deny to the individual physician the right to use his own best judgment in caring for patients and . . . would substitute . . . the judgment of the hospital pharmacist, purchasing agent, or staff committee."

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University of Minnesota Names 27 to Hospital Administrative Residencies

MINNEAPOLIS. — The University of Minnesota has announced the following residency appointments for its 1961 class in hospital administration:

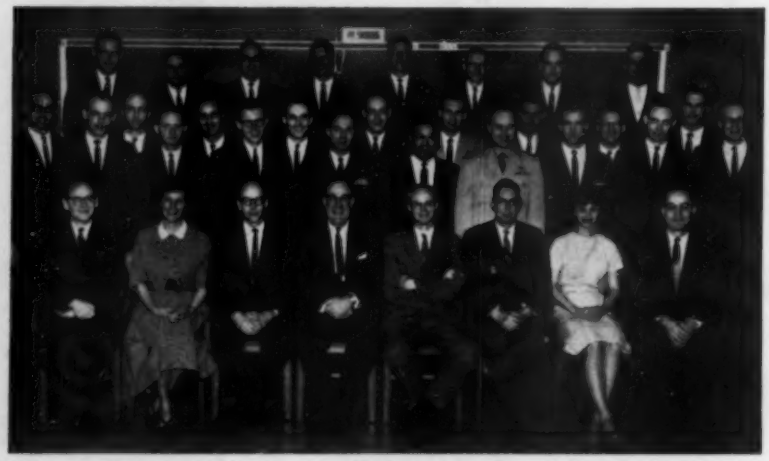
Joseph C. Brown to Eitel Hospital, Minneapolis; Frederick J. Bury to Highland Hospital, Rochester, N.Y.; Glenn D. Carlson to San Jose Hospital, San Jose, Calif.; John C. Coffey to St. Luke's Hospital, Kansas City, Mo.; Robert P. Dumminger to St. Luke's Hospital, Cleveland.

Alma Erb to Mount Sinai Hospital, Minneapolis; Edward M. Gillespie to Rochester Methodist Hospital, Rochester, Minn.; Lt. William Green Jr. to U.S. Naval Hospital, Philadelphia; Robert D. Hansen to Children's Hospital, San Francisco; Capt. John E. Hoffman Jr. to U.S.A.F. Hospital, Dayton, Ohio.

C. Jerome Jorgenson to Stormont-Vail Hospital, Topeka, Kan.; Robert K. Kasbohm to Charles T. Miller Hospital, St. Paul; John E. Kralewski to St. Barnabas Hospital, Minneapolis; Tsutomu Kumagai to University of Minnesota Hospitals, Minneapolis; Jackie R. Martin to Baptist Memorial Hospital, Memphis, Tenn.; Guy H. McKinstry Jr. to Memorial Hospital of South Bend, South Bend, Ind.

Roger W. Metz to Menorah Medical Center, Kansas City, Mo.; Donald C. Mills to Bethesda Hospital, St. Paul; William Monagle to Rhode Island Hospital, Providence; Scott S. Parker to Northwestern Hospital, Minneapolis; David L. Roach to St. Luke's Hospital, Milwaukee.

David C. Schmauss to St. Luke's Hospital, Duluth, Minn.; James E. Strand to Swedish Hospital, Minneapolis; William F. Towle to Johns Hopkins Hospital, Baltimore; Robert A. Tschetter to Baylor University Hospital, Dallas; Donald C. Wegmiller to Fairview Hospital, Minneapolis; John Kinnaird to Edinburgh, Scotland.



First row: J. Kinnaird, Dr. E. Lentz (associate professor), D. Dunn (instructor), J. A. Hamilton (program director), Dr. G. W. Anderson (director, school of public health), J. Stephan (associate director), A. Erb, H. Hoche (instructor). Second row: J. Coffey, E. Gillespie, D. Roach, W. Green Jr., T. Kumagai, J. Hoffman Jr., R. Kasbohm, S. Parker, R. Metz. Third row: D. Schmauss, G. McKinstry Jr., R. Hansen, D. Wegmiller, D. Mills, J. Kralewski, R. Dumminger, W. Towle, J. Strand. Fourth row: W. Monagle, C. Jorgenson, K. Hollenbaugh, G. Carlson, J. Brown, F. Bury, R. Tschetter, J. Martin.

State University of Iowa Names Hospital Residents

IOWA CITY, IOWA. — The State University of Iowa has announced the following residency appointments:

Jess Benton to Public Health Service, Bethesda, Md.; Walter M. Burnett to War Memorial Hospital, Sault Ste. Marie, Mich.; James Dalzell to Asbury Methodist Hospital, Minneapolis; Edward DeMeulenaere to Mercy Hospital, Council Bluffs, Iowa.

Donald Dodds to the Jewish Hospital Association, Cincinnati; Stephen Drury to St. Luke's Hospital, Cedar Rapids, Iowa; Ames Early to University of Minnesota Hospitals, Minneapolis; Jerry Harris to Morristown Memorial Hospital, Morristown, N.J.

Dwight Harshbarger to St. Luke's Hospital, St. Paul; Robert Holmes to University Hospitals, Iowa City; V. Duane Lacey to Trumbull Memorial Hospital, Warren, Ohio; Raymond Laughlin Jr. to Mountainside Hospital, Montclair, N.J.; Charles Peterson to Great Falls Clinic, Great Falls, Mont.

Loren Rice to Virginia Mason Hospital, Seattle; Raymond Rodgers to Veterans Administration Hospital, Iowa City; David Rykhus to Schoitz Memorial Hospital, Waterloo, Iowa; Howard Van Scoy Jr. to U.S.A.F., Lackland AFB, San Antonio, Tex.; Darryl Wahler to Pekin Public Hospital, Pekin, Ill.; Monte Welker to Milwaukee County Institute, Milwaukee.

Front row, left to right: faculty members, W. Wentz, J. Toussaint, Prof. G. Hartman, Prof. S. Levey, Dr. T. McCarthy, F. Patrick. Middle row: M. Welker, A. Early, J. Benton, E. DeMeulenaere, R. Rodgers, R. Holmes, S. Drury, L. Rice, D. Harshbarger. Back: V. Lacey, D. Dodds, D. Wahler, J. Dalzell, H. Van Scoy.

not a general-purpose antibiotic

Albamycin is not a broad-spectrum antibiotic, recommended for routine infections. It is specific for staphylococci (including resistant strains), and its use alone should (with the exceptions listed below) be limited to those cases in which staph is known or strongly suspected to be the causative organism.

Albamycin*

Indications — Albamycin is indicated in the treatment of staphylococcic infections, particularly in patients sensitive to other antibiotics or in the infections in which the organism is resistant to other antibiotics and sensitive to Albamycin, and in urinary tract infections due to microorganisms resistant to other commonly employed antibacterial agents but sensitive to Albamycin — notably certain strains of Proteus.

Administration and Dosage — Capsules and Syrup: The recommended dosage in adults is 500 mg. every twelve hours or 250 mg. every six hours, continued for at least forty-eight hours after the temperature has returned to normal and all evidence of infection has disappeared. In severe or unusually resistant infections, 0.5 Gm. every six hours or 1 Gm. every twelve hours may be employed. The dose for children is 15 mg. per kilogram of body weight per day for moderately acute infections; this may be increased to 30 to 45 mg. per kilogram of body weight per day for severe infections. These doses may be administered on schedules similar to those for adults.

Parenteral: intramuscularly—5 cc. of Albamycin solution may be used directly by slow injection deep into the gluteal muscle.

Intravenously — It is recommended that 5 cc. of Albamycin solution be diluted further with 250 to 1000 cc. of sterile injection solution of sodium chloride, Darrow's solution, or Ringer's solution and administered by intravenous infusion, or by diluting to a suitable quantity and administered by continuous drip infusion. **Do not use with dextrose solution.** When it is necessary to use a smaller volume intravenously, 5 cc. of Albamycin solution may be diluted to a minimum of 30 cc. with one of the above diluents and administered slowly over a period of five to ten minutes to avoid irritation of the vascular endothelium. The dosage for adults is 500 mg. Albamycin administered either intramuscularly or intravenously every twelve hours. For children with moderately acute infections, the dosage is 15 mg. per kilogram of body weight per day. The daily dosage should be administered in two divided doses at intervals of twelve hours. As soon as the patient's condition permits, parenteral Albamycin should be replaced with oral Albamycin therapy.

Side Effects — Albamycin is a substance of low toxicity but is capable of inducing urticaria and maculopapular dermatitis. Leukopenia, which was rapidly reversible, has been reported in approximately 1% of cases. All of these side effects disappear rapidly upon discontinuance of the drug. In a certain few patients, a yellow pigment has been found in the plasma. This pigment is a metabolic by-product of the drug which, however, may interfere with determination of bilirubin and icteric index. Its presence is not associated with abnormal liver function tests or liver enlargement.

Available — Albamycin, 500 mg., sterile, Mix-O-Vial.† Each Mix-O-Vial contains: 500 mg. Novobiocin (as novobiocin sodium), also 175 mg. Nicotinamide; 0.47 cc. N,N-Dimethylacetamide; 42.3 mg. Benzyl alcohol; 4.23 cc. water for injection. Albamycin Capsules. Each capsule contains: 250 mg. Novobiocin (as novobiocin sodium). Albamycin Syrup. 125 mg. per 5 cc. Each 5 cc. (one teaspoonful) contains: 125 mg. Novobiocin (as novobiocin calcium). Preserved with methylparaben, 0.075%, and propylparaben, 0.025%.

*Trademark, Reg. U. S. Pat. Off. — The Upjohn brand of crystalline novobiocin sodium. †Trademark, Reg. U. S. Pat. Off.

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Five Newark Hospitals Join Forces To Raise $25 Million for Modernization and Expansion

NEWARK, N.J. — It's fund raising time with a bang for hospitals in this city.

Five voluntary hospitals here have banded together to raise $25 million. The money will be used to finance a modernization and expansion program at American Legion, Beth Israel, Columbus, St. James, and St. Michael's hospitals.

Meanwhile, the other voluntary hospitals in the area, which are linked together as United Hospitals, plan to raise $14 million to help build a complete medical center for northern New Jersey.

According to Donald Rosenberger, director of the hospitals, the 1000 bed center "will be equal to the future — a future which looks forward to a doubled population of more than eight million in the center's service area by 1985."

The fund raising effort and the reasons for it were the subject of a four part, front page series of articles in the *Newark Evening News*, which cited many of the immediate needs of the institutions.

Emergency Care Boom Noted in Cleveland Area

CLEVELAND. — A boom in the use of hospital emergency services has been noted here.

Hospitals in Cuyahoga and four neighboring counties last year reported a resounding increase of 73,025 visits over the previous year. The five-county total in 1960 was 375,636 visits.

John R. Mannix, vice president of Blue Cross of Northeast Ohio, reported figures showing a steady rise dating back to 1935 to the *Cleveland Plain Dealer*.

Rather than reflecting an increase in the number of accidents and "traditional" emergencies, hospital officials said the rise was chiefly attributable to increased use of hospital emergency departments by nonemergent medical cases.

Sidney Lewine, director of Mount Sinai Hospital, explained that people are using the emergency room in cases where formerly they would have called a doctor.

He had little expectation that the movement toward hospital-centered emergency care would be slowed or halted, the *Plain Dealer* reported.

"It is possible that there is nothing wrong with it," he said, "if people can be well cared for."

Two Former Night Club Operators Propose To Build Hospital

MORTON GROVE, ILL. — Investigation has been ordered into the bid of two former night club operators to open a hospital in this Chicago suburb.

The pair, whose former business venture in Chicago was closed by the city in 1950, proposed to convert a nursing home into a $3 million hospital.

A five-man committee was appointed by the Morton Grove village board "due to the adverse publicity" surrounding the project, the *Chicago Daily News* reported.

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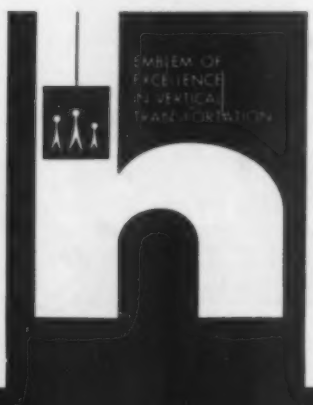

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Medical Society To Share Health Ideas With Public

SEATTLE. — An arrangement to "cross-pollinate" health care ideas with representative public groups has been organized by the King County Medical Society in Washington State.

The society's Commission on Health Care includes about a dozen sections covering such areas as labor unions, legislators, hospitals, insurance companies, community service, and general problems. Each section is made up of about six doctors and an equal number of lay persons. Luncheon meetings are usually held every two or three weeks.

Response both from society members and from the community has been promising, according to Dr. Hugh W. Jones, Seattle, society president, who with Dr. James W. Haviland, Seattle, president-elect, organized the commission.

The first problem area tackled is health care for migratory workers. The commission plans to extend its program to include all phases of medical care.

Pennsylvania Court Upholds Immunity Law

PITTSBURGH. — The charitable immunity of hospitals was reaffirmed here by the Pennsylvania supreme court in a decision upholding a 73 year old law.

The decision was made on two separate cases involving injury to Philadelphia area residents through alleged incompetence on the part of hospital employes, the *Pittsburgh Press* reported.

The court, by a 4 to 3 decision, refused to admit the suits to trail on the basis of a decision by the same court in 1888 which made hospitals, as "charitable" institutions, immune to lawsuits for negligance or incompetence.

In addition to the minority, it was pointed out that some members of the majority believe the law may be out of step, but think that changing it is a job for the legislature, not the courts.

Organizational Dispute Leads to 22 Resignations

KEWANEE, ILL. — Resignations from 22 of Kewanee Public Hospital's 46 nurses have followed the firing of the obstetrical supervisor.

The Illinois Nurses Association contends the supervisor was fired because she attempted to organize a chapter at the hospital, the *Chicago Tribune* reported.

Elizabeth Baethke, hospital administrator, said the supervisor was dismissed for spending too much time away from her duties while discussing I.N.A. organizational work with other nurses.

Maine Hospitals Approve Hiring Full-Time Executive

ROCKLAND, ME. — Final action to permit the hiring of a full-time executive secretary was taken by the Maine Hospital Association at its annual meeting here June 6 and 7.

Such action had been under discussion for several years.

At the same time the association elected as president Philip K. Reiman, associate director, Maine Medical Center, Portland. Mr. Reiman succeeds Raymond H. Walton of Gardiner General Hospital, Gardiner.

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For additional information, use postcard facing back cover.

Examiners Report Patient Funds, Drugs Mishandled at Ohio State Hospital

MASSILLON, OHIO. — Mishandling of patient funds and of drugs purchased by the state for patients at Massillon State Hospital here have been reported by state examiners.

Findings were made in the report against a former superintendent and a former woman employe of the hospital, according to the *Cleveland Press*.

Two findings, one of $771 and one of $231, were made against the former superintendent because, the examiners said, he transferred those amounts from the accounts of patients who had died.

A finding of $150 was made against a former employe and her bonding company. The examiners said she admitted that when patient accounts did not balance she would make out cards to fit the difference while she continued to hunt for the errors.

The investigation also turned up several other discrepancies and shortages in the handling of patient funds and valuables, the newspaper report indicated.

In addition, examiners reported they found that 33 hospital employes and six former employes had prescriptions filled at the hospital pharmacy without charge.

The personal use of state food, supplies or equipment of any kind is forbidden state hospital employes.

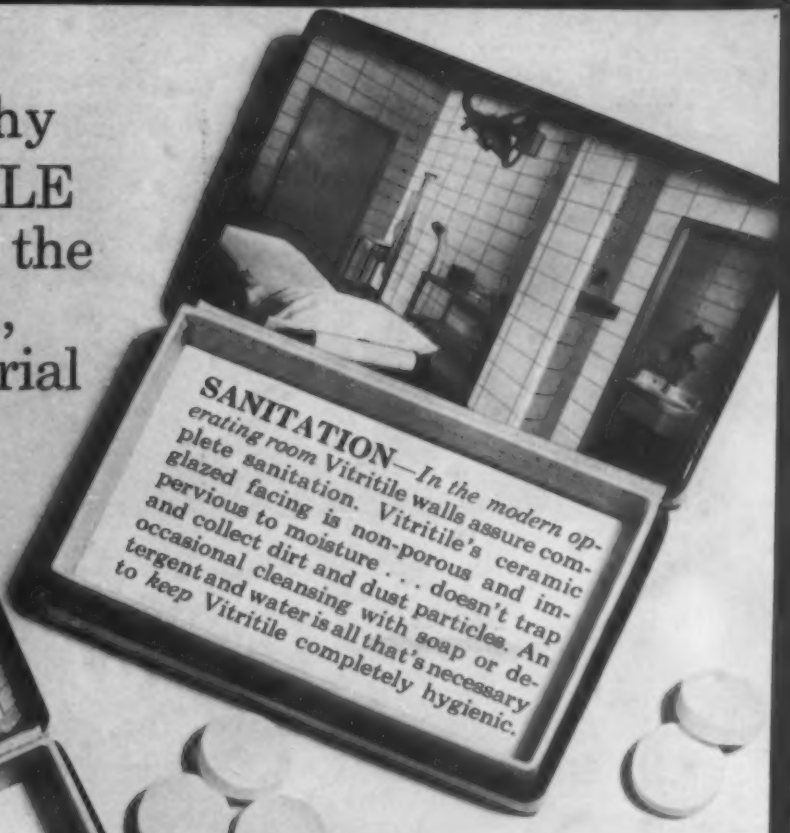
Woman's and Magee Hospitals Agree To Merge

PITTSBURGH. — Merger of Woman's and Elizabeth Steel Magee hospitals here has been approved by the boards of both hospitals.

The trustees of Woman's Hospital have agreed to sell their present facility to the University of Pittsburgh and with the money received to add a new wing to Magee hospital. Construction of the wing is expected to be completed during the summer of 1963.

Dr. Hilda H. Kroeger, administrator of Magee hospital since 1951, and Dr. Milton L. McCall, medical director of Magee since 1959, will serve the consolidated hospital in these same capacities, it was announced.

Three reasons why NATCO VITRITILE was prescribed for the Shreveport, La., Schumpert Memorial Hospital



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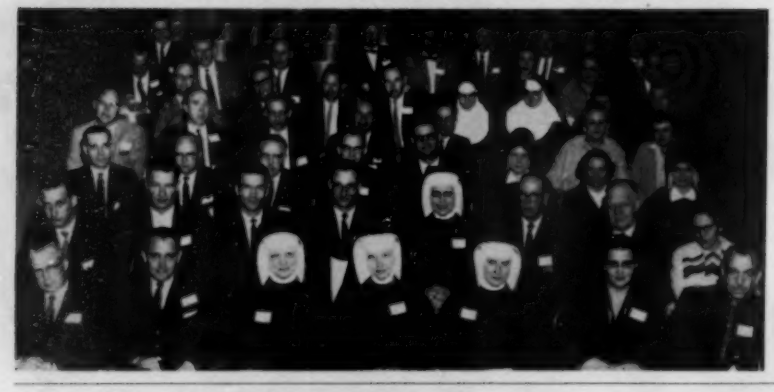
Accountants Group Holds First Institute



Accountants, hospital administrators, and Blue Cross representatives discuss principles for pricing hospital services. The institute on pricing was the first project of the joint Colorado-Wyoming chapter of the American Association of Hospital Accountants. The meeting of the group was held at the University of Wyoming.

Accountants Association Elects Ernest C. Laetz

CHICAGO. — Ernest C. Laetz is the newly elected president of the American Association of Hospital Accountants. He took office June 1. Mr. Laetz is business manager, University of Michigan Hospital, Ann Arbor.

Ernest C. Laetz

Other officers elected to serve with Mr. Laetz are: first vice president, Harry O. Humbert, Roosevelt Hospital, New York; second vice president, E. Gilbert Slatton, Eugene Wuesthoff Memorial Hospital, Rockledge, Fla.; treasurer, William E. Culbertson, Wood County Hospital, Bowling Green, Ohio.

New directors elected by the association are: Sister Mary Michaeleen, St. Joseph's Hospital, South Bend, Ind.; Stanley W. Shepard, New Britain General Hospital, New Britain, Conn.; Clifford C. Losberg Jr., Ochsner Foundation Hospital, New Orleans.

N.U. Sponsors Sessions on Medical Services

CHICAGO. — Thirty sessions on "Administration of Medical Services" are being sponsored by the evening division of Northwestern University, in cooperation with faculty and alumni of the university's program in hospital administration.

Registration will be limited to 25 selected students enrolled for the entire series, Dean Daniel R. Lang of the evening division announced. Tuition will be $180 for the noncredit course.

Laura G. Jackson, associate professor of hospital administration, is general coordinator of the program.

BURROUGHS HOSPITAL ACCOUNTING MACHINES REDUCE COSTS, PROVIDE COMPLETE CONTROL OF PATIENT ACCOUNTS

The scene: Expanding Greenville General Hospital, Greenville, S. C. **The job:** Accounting records of 25,000 in-patients and 100,000 out-patients annually. **The equipment:** Burroughs Series F Accounting Machines. **The results,** in the words of Director Robert E. Toomey: "Burroughs Accounting Machines chosen largely on the basis of our satisfaction with other Burroughs equipment throughout the hospital greatly facilitate our 'Columnar Plan' accounting. Together, the plan and the equipment have increased speed and accuracy, drastically cut direct operating costs, and given us complete control of patient records." Burroughs—TM

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Southeastern Groups Elect Officers During Convention

MEMPHIS, TENN. — Howard Clem, George H. Lanier Memorial Hospital, Langdale, Ala., was elected president of the Southeastern Society of Hospital Pharmacists. The meeting was held concurrently with the Southeastern Hospital Conference's annual assembly.

Other officers elected were: vice president, Owen Crutcher, Memorial Hospital, Inc., Johnson City, Tenn., and secretary-treasurer, Mary Wernersbach, Mount Sinai Hospital, Miami Beach.

Officers elected at the Southeastern Hospital Conference of Medical Record Librarians are: president, Blanche Borders, Highland Avenue Baptist Hospital, Birmingham, Ala.; president-elect, Mary Knox Sanders, Jackson Memorial Hospital, Miami; secretary, Annette Nason, Coahoma County Hospital, Clarksdale, Miss., and treasurer, Louise Matzner, Baptist Memorial Hospital, Memphis, Tenn.

Officers named for 1961-62 at the Southeastern Hospital Conference of Dietitians are: president, Helen Jenkins, Emory University, Atlanta, Ga.; president-elect, Faye G. Young, Veterans Administration Hospital, Atlanta, Ga.; vice president, Shirley Smith, Lafayette Memorial Sanitarium, Lafayette, La.; secretary, Janet P. Mastin, University of Alabama Medical Center, Birmingham, and treasurer, Charlotte D. Jackson, Emory University Hospital, Atlanta, Ga.

Hospital Union Gains 5 Per Cent Wage Raise

CHRISTOPHER, ILL. — Hospital workers here represented by United Mine Workers District 50 have negotiated a contract renewal that provides a 5 per cent wage increase over a two-year period.

The increase is estimated to range from between 37 and 48 cents more per day, according to *Service Labor Report*.

The agreement also provides a 12 day paid vacation after one year's employment, noncontributory medical-surgical-hospitalization coverage for employes and dependents, rest periods, and two meals for overtime workers.

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St. Louis University Announces Residencies for 35 Hospital Administration Students

ST. LOUIS. — The department of hospital administration at St. Louis University has announced its residencies for 1961. They are:

Sr. Roberta Francis Blomquist to Mount Carmel Hospital, Columbus, Ohio; Sr. Marie Edgar Cooney to Sacred Heart Hospital, Spokane, Wash.; Sr. M. Cherubim Cukla to Good Samaritan Hospital, Dayton, Ohio; Sr. Thomas Aquinas Dinan to St. Francis' Hospital, Hartford, Conn.

Sr. Margaret Cortona Ebbing to St. Vincent's Hospital, New York; Sr. Mary Eustace Farrell to St. Vincent Hospital, Worcester, Mass.; Robert Edwin Frank to Barnes Hospital, St. Louis; Lt. Frank J. Fresques to Chanute Air Force Base, Rantoul, Ill.; Sr. Francis Marie Garvey to St. Mary's Hospital, Grand Rapids, Mich.

Sr. Mary Hilary Hacker to Good Samaritan Hospital, Cincinnati; Sr. Jean Frances Haug to Santa Rosa Hospital, San Antonio, Tex.; Sr. Mary Huberta Herdeman to St. Vincent's Hospital, Erie, Pa.; Donald James Hinnen to Christian Welfare Hospital, East St. Louis, Ill.; Sr. Margaret Rosita Kenny to St. Vincent's Hospital, New York.

Ned E. Kinney to St. Louis City Hospital, St. Louis; Sr. M. Justin Krieg to St. Joseph's Hospital, Phoenix, Ariz.; Sr. M. Dolorosa Krieter to St. Mary-Corwin Hospital, Pueblo, Colo.; Sr. M. Judith Kuhn to St. Mary's Hospital, Grand Rapids, Mich.; Sr. Regina Lietz to Saint Joseph's Hospital, South Bend, Ind.

Charles F. McCarthy to Lynn Hospital, Lynn, Mass.; Sr. M. Domitilla Martinko to Holy Redeemer Hospital, Meadowbrook, Pa.; R. Lee Meuret to Saint Catherine's Hospital, Omaha; Sr. M. Clarence Naughton to St. Francis' Hospital, Hartford, Conn.; Bob J. Pratt to Methodist Hospital, Memphis, Tenn.; Sr. M. Pauline Racich to Mercy Hospital, Toledo, Ohio; William J. Riordan to Waltham Hospital, Waltham, Mass.

Sr. M. Honesta Pozdol to Sacred Heart Hospital, Yankton, S.D.; Frank C. Ryan to St. Joseph Hospital, Syracuse, N.Y.; Sr. Margaret Mary Sikorski to St. Elizabeth Hospital, Dayton, Ohio; Edward J. Spillane to Santa Rosa Hospital, San Antonio, Tex.; Sr. St. Jerome Stamschror to St. John's Hospital, Santa Monica, Calif.

Sr. John Marita Tighe to Carney Hospital, Boston; Sr. M. Eileen Van Ackeren to St. Mary-Corwin Hospital, Pueblo, Colo.; Sr. Dolores Marie Wuebker to St. Joseph's Hospital, Paterson, N.J.; Sr. Marie Rebecca Wright to St. Mary's Hospital, Duluth, Minn.

Front row, left to right: Sr. M. Cherubim, Sr. M. Rosita, Sr. M. Eileen, Sr. Thomas Aquinas, Sr. D. Marie, Sr. R. Francis, Sr. M. Rebecca, Sr. M. Edgar, Sr. St. Jerome, Sr. M. Honesta, Sr. M. Pauline. Second row: Sr. M. Judith, Sr. F. Marie, Sr. M. Cortona, Sr. M. Eustace, Sr. M. Huberta, Sr. Regina, Sr. M. Hilary, Sr. M. Mary, Sr. M. Domitilla, Sr. J. Marita, Sr. J. Frances, Sr. M. Dolorosa, Sr. M. Justin, Sr. M. Clarence. Third row: W. I. Christopher (instructor), R. Frank, F. Ryan, Lt. F. Fresques, B. Pratt, N. Kinney, C. McCarthy, E. Spillane, W. Riordan, R. Meuret, C. Berry (assoc. dir.), P. Donnelly (instructor).

MODERN HOSPITAL INDEX

The index to the last six issues of this year's magazines (January through June 1961, Vol. 96) has been printed separately. For a complimentary copy, please send us a post card. Persons who have received previous indexes will be sent the latest index without further correspondence.

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COMING EVENTS

AMERICAN ASSOCIATION OF BLOOD BANKS, Drake Hotel, Chicago, Oct. 25-28.

AMERICAN ASSOCIATION OF HOSPITAL CONSULTANTS, Shelburne Hotel, Atlantic City, Sept. 23.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Benjamin Franklin Hotel, Philadelphia, Oct. 9-12.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Convention Hall, Atlantic City, Sept. 25-28.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Convocation, Convention Hall, Atlantic City, Sept. 24.

AMERICAN COLLEGE OF SURGEONS, Conrad Hilton Hotel, Chicago, Oct. 2-6.

AMERICAN DENTAL ASSOCIATION, Sheraton Hotel and Convention Hall, Philadelphia, Oct. 16-19.

AMERICAN DIETETIC ASSOCIATION, Sheraton-Jefferson Hotel and Kiel Auditorium, St. Louis, Oct. 24-27.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, Convention Hall, Atlantic City, Sept. 25-28.

AMERICAN NURSING HOME ASSOCIATION, Pick-Carter Hotel, Cleveland, Oct. 2-6.

AMERICAN PUBLIC HEALTH ASSOCIATION, Cobo Hall, Detroit, Nov. 13-17.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC., Statler-Hilton Hotel, Los Angeles, Oct. 22-27.

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS, Olympic Hotel, Seattle, Sept. 29-Oct. 8.

ARIZONA HOSPITAL ASSOCIATION, Ramada Inn, Phoenix, Oct. 19, 20.

ASSOCIATED HOSPITALS OF ALBERTA, Hotel Palliser, Calgary, Oct. 10-12.

ASSOCIATION OF DELAWARE HOSPITALS, Dover, Oct. 12.

BRITISH COLUMBIA HOSPITAL ASSOCIATION, Hotel Vancouver, Vancouver, Oct. 17-19.

CALIFORNIA HOSPITAL ASSOCIATION, San Diego, Oct. 23-27.

COLLEGE OF AMERICAN PATHOLOGISTS, Seattle, Oct. 1-7.

COLORADO HOSPITAL ASSOCIATION, Boulder, Oct. 22-25.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Penn Harris Hotel, Harrisburg, Oct. 17, 18.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 10.

IDAHO HOSPITAL ASSOCIATION, Elks Lodge, Boise, Oct. 16, 17.

ILLINOIS HOSPITAL ASSOCIATION, St. Nicholas Hotel, Springfield, Nov. 30, Dec. 1.

INDIANA HOSPITAL ASSOCIATION, French Lick Hotel, French Lick, Nov. 1-3.

(Continued on Next Page)

(*Continued From Preceding Page*)

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 9, 10.

MARYLAND-D.C. HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, Nov. 8-10.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, April 25-27.

MINNESOTA HOSPITAL ASSOCIATION, Leamington Hotel, Minneapolis, Nov. 9, 10.

MISSOURI HOSPITAL ASSOCIATION, Sheraton-Jefferson Hotel, St. Louis, Oct. 11-13.

MONTANA HOSPITAL ASSOCIATION, East Glacier Hotel, East Glacier Park, Sept. 7, 8.

NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC., St. Paul Hotel, St. Paul, Oct. 2-6.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Oct. 12, 13.

OKLAHOMA HOSPITAL ASSOCIATION, Mayo Hotel, Tulsa, Nov. 2, 3.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 23-25.

OREGON ASSOCIATION OF HOSPITALS, Eugene Hotel, Eugene, Oct. 22-24.

RADIOLOGICAL SOCIETY OF NORTH AMERICA, Palmer House, Chicago, Nov. 26-Dec. 1.

SASKATCHEWAN HOSPITAL ASSOCIATION, Hotel Saskatchewan, Regina, Oct. 5, 6.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Sheraton-Cataract Hotel, Sioux Falls, Oct. 17, 18.

VERMONT HOSPITAL ASSOCIATION, Vermont Hotel, Burlington, Oct. 11, 12.

VIRGINIA HOSPITAL ASSOCIATION, John Marshall Hotel, Richmond, Nov. 9, 10.

WASHINGTON STATE HOSPITAL ASSOCIATION, Yakima, Oct. 26, 27.

WEST VIRGINIA HOSPITAL ASSOCIATION, Morgan Hotel, Morgantown, Oct. 19-21.

1962

AMERICAN HOSPITAL ASSOCIATION, Midyear Meeting, A.H.A. Headquarters, Chicago, Jan. 31, Feb. 1.; annual meeting, Chicago, Sept. 17-20.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 23-25.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 25-27.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 23.

ABOUT PEOPLE

(*Continued From Page* 86)

Charles B. Womer has been appointed associate director of University Hospitals of Cleveland. He is a graduate of the program in hospital administration of Columbia University and joined the staff of University Hospitals in 1952 as an administrative resident. He was named administrative assistant in 1953 and assistant director in 1957.

Solomon L. Siegel is the new assistant executive director of Maimonides Hospital of Brooklyn, Brooklyn, N. Y. He was formerly an associate executive director at the Jewish Chronic Disease Hospital, Brooklyn, N. Y. Mr. Siegel is a past president of the American Association of Hospital Purchasing Agents.

William L. Shepherd has been named administrative assistant at University Hospital and Hillman Clinic, Birmingham, Ala. Previously, he was administrator of Central State Psychiatric Hospital, Lakeland, Ky. Mr. Shepherd holds a master's degree in hospital administration from Northwestern University.

William Shepherd

Fred C. Washburn has been ap-

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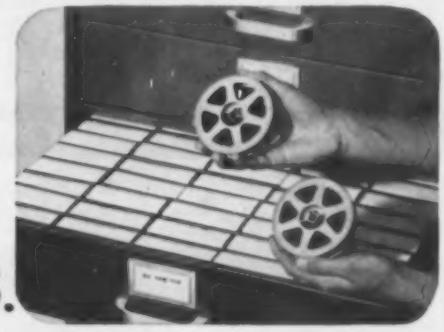

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pointed assistant director of Aultman Hospital, Canton, Ohio. He holds a master's degree in hospital administration from Yale University. **Albert Gilbert** was named administrative assistant at Aultman. He received his master's degree in hospital administration from the University of Michigan.

Department Heads

Lawrence G. Nelson has become manager of buildings and services at Chicago Wesley Memorial Hospital, Chicago. Other appointments announced by Wesley are: **Eleanora Sense** to director of dietetics; **Bernard Hudik** to food service manager; **Augustine Gunn** to administrative assistant for social service, volunteers, and administrative assistants in charge of evening and week end services and the diagnostic unit; **John T. Franklin** to administrative assistant in charge of evening services.

Ethel Bass is the new superintendent of nursing service at Lawrence County Hospital, Monticello, Miss. Miss Bass succeeds **Mrs. Ronaldo Turner.**

James H. DeBebord is the new business manager of Memorial Hospital, Owosso, Mich.

Jean Whiston has been named director of public relations and volunteers at Somerset Hospital, Somerville, N.J. Miss Whiston succeeds **Sylvia Papier.**

Sister Mary Anthony Ratermann, S.F.P., is the new director of nursing at St. Mary's Hospital, Quincy, Ill. She succeeds **Sister M. Lucy Farrell, M.S.N.**

Dr. L. Burton Parker has been named director of the physical therapy and rehabilitation departments, Florida Sanitarium and Hospital, Orlando. At the same time it was announced that **Donald Owsley** has been named chief pharmacist, and **Douglas Buckner,** director of public relations.

Miscellaneous

Isadore Sydney Falk and **John D. Thompson** have been appointed to the public health faculty of Yale University. Prof. Falk has been named professor of public health for medical care and Mr. Thompson has been named associate professor of public health for hospital administration. An authority on social security legislation, Prof. Falk was for many years associated with federal agencies and has served as an adviser on health services for several foreign governments. Mr. Thompson was assistant director of Montefiore Hospital, New York, from 1950 to 1956. Since 1956 he has been research associate in public health and hospital administration at Yale. He also directed a Yale research project on hospital design and function.

Deaths

William D. May, administrator of Memorial Hospital, Modesto, Calif., died recently at the age of 47. He had been administrator of the hospital for eight years. Mr. May was a graduate of Ohio State University and was a member of the American College of Hospital Administrators. He is succeeded by **Willard J. Leuthard,** who has served as assistant administrator of Memorial Hospital for the last four years.

Henry B. Kidder, assistant director of Aultman Hospital, Canton, Ohio, died recently. He graduated with the first class in hospital administration at Yale University.

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POSITIONS WANTED

ACCOUNTANT—29; 4½ years experience as accountant and auditor in hospitals; business manager 35 beds; office manager 311-beds; auditor 175, 280-beds; desires position as accountant or comptroller. Apply MW 107, The MODERN HOSPITAL.

ADMINISTRATOR—Assistant or purchasing director; retiring army officer, 22 years experience in hospital administration, supply and procurement. Reply to MW 104, The MODERN HOSPITAL.

ADMINISTRATOR—Small JCAH affiliated hospital or assistant administrator medium or large general hospital under ACHA administrator; BBA and MSHA Degrees; mature; experienced in all phases of administration; available for interview immediately or 63rd AHA meeting. For resume write MW 106, The MODERN HOSPITAL.

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ASSISTANT ADMINISTRATOR—30; MS, Columbia; 1 yr, res, univ hsp; 1 yr adm asst & 1 yr asst dir 1000-bd med schl hsp; seeks asst adm 300-bds or less, metropolitan area; Mid-Atlantic or Pac area.

ANESTHESIOLOGIST — 36; Southerner; Dipl; FACA; seeks chiefshp, warmer climate in fee-for-serv; now grossng $25,000.

PATHOLOGIST—40; Dipl, CP & PA; 2 yrs asst chief, lab services, very large gen; seeks to broaden exper; pref E.

RADIOLOGIST—34; Cert, diag & thera; 4 yrs res 1 yrs res rad ther; 2 yrs asst rad univ hsp; min $20,000; dir or chief of rad, hsp Mid-E or E; highly recomm.

INTERSTATE MEDICAL PERSONNEL BUREAU

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ADMINISTRATOR—Master's Degree; age: 35 yrs; 2 yrs bus mgr: 8 yrs admin, 140-bed Ohio hospital; any location.

ASSISTANT ADMINISTRATOR — MHA Degree, 1956; age: 35; 2 yrs large teaching hosp, Pa. past 3 yrs, administrative asst, New England hospital.

INTERSTATE—Continued

BUSINESS MANAGER—Degree in Accounting; 8 yrs bus mgr, 185-bed Ohio hosp; prefers southern or southwestern states.

PERSONNEL MANAGER—B.S. Degree; 10 yrs experience in bus admin., western organizations; at present public relations dir, 250 bed Ohio hosp; prefers Mid-west.

ADMINISTRATIVE ASSISTANT—M.H.A. Degree, mid-western univ, 1959; 2 yrs exp, 275-bed Ill hospital; available.

EXECUTIVE HOUSEKEEPER—Age: 50; 9 yrs experience, 300-bed eastern hospital.

NURSE SUPERINTENDENT—B.S. Degree; 18 yrs experience as nurse director, 50-125 bed hospitals, Pa, New York.

POSITIONS OPEN

ADMINISTRATIVE ASSISTANT in personnel; ability to talk and write effectively plus a working knowledge of techniques of supervising a newly created personnel department, are essential requirements; about 6M/year; 250-beds, east central U.S. Write MO 352, The MODERN HOSPITAL.

ANESTHETIST—Nurse; to join anesthesiologist and nurses. Write to MO 341, The MODERN HOSPITAL.

ANESTHETIST—Nurse; 95-bed general hospital, fully accredited, located in western Pennsylvania; good opportunity; salary open; many fringe benefits. Write to MO 342, The MODERN HOSPITAL.

ANESTHETIST—Nurse; for 100-bed general hospital to complete staff of three; new, modern air-conditioned hospital located in midwest university town; salary open dependent on qualifications and experience. Write Jack Edmundson, Administrator, DOCTORS HOSPITAL, Carbondale, Illinois.

ANESTHETIST—Nurse; 200-bed Veterans Administration general hospital, fully accredited; participate in all Federal employee fringe benefits; beginning salary $4760 to $7560. Apply Manager, VA HOSPITAL, POPLAR BLUFF, MO.

ANESTHETIST—Nurse; 90-bed hospital, population 16,000, college town, many fringe benefits, hospitalization included; salary open. Contact Administrator, JAMESTOWN HOSPITAL, Jamestown, North Dakota.

ANESTHETIST—Nurse; for 604-bed general hospital, no pediatric department, 40 hour week, plus overtime, salary open, generous employee benefits. Apply Personnel Office, AKRON CITY HOSPITAL, 525 East Market Street, Akron 9, Ohio.

ANESTHETIST—Nurse; $500, new and modern surgery, unusually strong and well diversified surgical staff; good opportunity in new 260-bed expanding hospital; college town location; good personnel policies, 40 hour week, 7 holidays, hospitalization, social security. Apply F. J. O'Brien, Administrator, CHAMBERSBURG HOSPITAL, Chambersburg, Pennsylvania.

ANESTHETIST—R.N. preferred; seventy-bed hospital, Northwestern Pennsylvania; hospital fully accredited. Write Administrator, COMMUNITY HOSPITAL, N. Fraley Street, Kane, Pennsylvania.

DIETITIAN—Opening available immediately; midwest college town; 75-bed hospital with 60-bed expansion in near future; salary open. Apply MO 345, THE MODERN HOSPITAL.

DIETITIAN—ADA; Expanding midwestern pharmaceutical company has opening in dietetic services program; duties include planning diets, performing dietetic library research, answering professional correspondence, and representing company at medical, dietetic, and lay meetings. Salary $6,000 to $6,500 depending upon qualifications; all inquiries confidential. Send resume to MO 350, The MODERN HOSPITAL. All qualified applicants will receive consideration for employment without regard to race, color or national origin.

DIETITIAN—Must have hospital experience and be qualified to take complete charge of this southern California hospital of 75-beds in the Pasadena area on a full-time basis; salary open. Reply R. M. Mershon, Personnel Director, P. O. Box 74, Temple City, California.

DIETITIAN—An opportunity for the qualified dietitian to make full use of her abilities in an interesting and rewarding position; ADA registration or comparable experience required; fully accredited, 250-bed, teaching, non-sectarian, community hospital; $2,000,000 development program underway, which will provide completely new dietary department, additional bed capacity, plus many other modern facilities. Apply Personnel Director, RAVENSWOOD HOSPITAL, 1931 W. Wilson, Chicago 40, Illinois.

DIETITIAN—Therapeutic; A.D.A. ST. MARY OF NAZARETH HOSPITAL, 1120 North Leavitt Street, Chicago 22, Illinois; open now; will direct and supervise diets for patients, 278-bed hospital; 40 hour week; good salary and benefits, opportunity for advancement. Apply to Miss Mary Annes, Personnel Director.

DIETITIAN—Excellent opportunity for ADA registered dietitian planning modified diets, writing modified menus, selecting and training employees and directing work of dietary supervisors; 500-bed hospital with 180 dietary employees; salary commensurate with training and experience; liberal benefits. Reply Personnel Director, IOWA METHODIST HOSPITAL, Des Moines 14, Iowa.

DIETITIAN—Or food service manager; for 60-bed general hospital in west central Michigan; to be in charge of kitchen and food service; salary open. Contact Ralph Tarr, Administrator, GRAND HAVEN MUNICIPAL HOSPITAL, Grand Haven, Michigan.

DIETITIAN—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries beginning at $350.00 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians allowed overtime work and are paid at an hourly rate based on monthly salaries; three weeks vacation; social security; Blue Cross. Apply Director of Dietetics, BARNES HOSPITAL, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Preferably registered, or at least well qualified to handle 272-bed general hospital; salary at least $25.00-$30.00 per day with room and board; beautiful nurses' home with all private rooms nicely furnished; responsible for preparing menus and special diets and supervising personnel in entire department; purchasing is done through full-time purchasing agent. Write giving full qualifications to DOVER GENERAL HOSPITAL, Jardine Street, Dover, New Jersey, c/o C. T. Barker, Director.

DIETITIAN—Chief; A.D.A.; with supervisory experience for 160-bed 27 bassinet gen-

(Continued on page 160)

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POSITIONS OPEN

eral hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open, 4 weeks vacation; social security; Blue Cross and Blue Shield available. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

DIRECTOR HOSPITAL FOOD SERVICE—Excellent opportunity in 600-bed hospital with A.D.A. internship, recently completed addition with the most modern cafeteria and food service; approved school of nursing, resident-intern program; generous benefit program with progressive personnel policies. Apply Personnel Director, THE CHRIST HOSPITAL, Cincinnati 19, Ohio.

DIRECTOR OF NURSING EDUCATION—For immediate placement in a hospital affiliated school of nursing accommodating 90 students located 4 blocks from the campus of the University of Illinois and 2 hours by train from Chicago; school is fully staffed with on-going program; hospital fully accredited by the JCAH; starting salary $7200 plus benefits; applicants must have a masters in nursing education. Write The Administrator, BURNHAM CITY HOSPITAL, Champaign, Illinois.

DIRECTOR SCHOOL OF NURSING—Assistant; Diploma school, 80 students, affiliated with Weschester Community College for basic sciences; Masters degree in nursing education or equivalent plus minimum of 5 years experience as instructor required; 200-bed voluntary general hospital; JCAH accredited; 35 miles from New York City; good personnel policies; salary commensurate with degree and experience. Apply Director of Nursing, WHITE PLAINS HOSPITAL, White Plains, New York. WHite Plains 9-4500, ext. 255.

DIRECTOR OF NURSING—Modern JCAH approved 100-bed general hospital; no school of nursing; beautiful southern Vermont community, 3 hours drive from Boston; private apartment available; salary commensurate with qualifications; willing to consider experienced assistant director desirous of promotion to director; excellent fringe benefits, superior security. Apply MO 346, The MODERN HOSPITAL.

DIRECTOR OF NURSING—Salary $9,000-$11,000; to direct nursing service and education in JCAH approved 200-bed hospital located between New York City and Boston; Masters Degree and experience required; fringe benefits include excellent, non-contributory retirement plan and life insurance, one month's vacation, hospitalization insurance, etc. living quarters available. Write MO 351, The MODERN HOSPITAL.

DIRECTOR—Social service; female; in very active, fully approved, general hospital—247-bed capacity; currently expanding to 310-beds; located in the Hudson River Valley; pleasant working conditions, liberal personnel policies; state minimum salary requirement. Write to MO 340, The MODERN HOSPITAL.

EXECUTIVE DIRECTOR—Royal Alexandra Hospital, Edmonton, Alberta; 729-bed general hospital now adding 600 more beds; large new school for nurses; medical undergraduate teaching; either medical or non-medical background acceptable; experience needed; state qualifications, salary expected and when available; please furnish references. Apply B. C. Whittaker, Q.C., Chairman, EDMONTON HOSPITAL BOARD, Room 304 Canadian Bank of Commerce Building, Edmonton, Alberta.

HOUSEKEEPER—Executive; A challenging opportunity in a modern and progressive hospital in the midwest; 2 to 3 years experience as executive or assistant housekeeper necessary; extensive benefit program, including 3 weeks vacation after 1 year and 4 weeks after 5 years. Write MO 348, The MODERN HOSPITAL.

HOUSEKEEPER—Executive: A very desirable position available immediately for an experienced housekeeper to carry on a well organized training program and direct our large housekeeping staff; we are a 450-bed general hospital with complete modern facilities; you will receive many employee benefits including an excellent retirement program. Please mail your professional qualifications to the Personnel Director, BUTTERWORTH HOSPITAL, Grand Rapids 3, Michigan.

INSTRUCTOR—In nursing care of children; diploma school; 300-bed hospital close to Baltimore and Washington; Bachelors degree preferred. Apply Director of Nursing, WASHINGTON COUNTY HOSPITAL, HAGERSTOWN, Maryland.

INSTRUCTORS—Medical surgical nursing; for hospital school of nursing; 324-bed JCAH accredited (when present construction is complete); hospital one block from main transportation line to city; apartments available close to hospital; liberal personnel policies; opportunity for study and time arranged. For further information write Director of Nursing, LUTHERAN MEDICAL CENTER, 4520 Fourth Avenue, Brooklyn 20, New York.

INSTRUCTOR—Medical & surgical; Degree in Nursing or Nursing Education, 150-bed hospital, modern; Central Pennsylvania; $4800 to start; send background information. CLEARFIELD HOSPITAL, Turnpike Avenue, Clearfield, Pennsylvania.

INSTRUCTOR—Dietary clinical; school of nursing (300 students) for 570-bed general hospital in residential suburb; patient-centered program of nutrition instruction; 40 hour week; salary open with liberal fringe benefits. Write qualifications and experience to Personnel Director, THE READING HOSPITAL, West Reading, Pennsylvania.

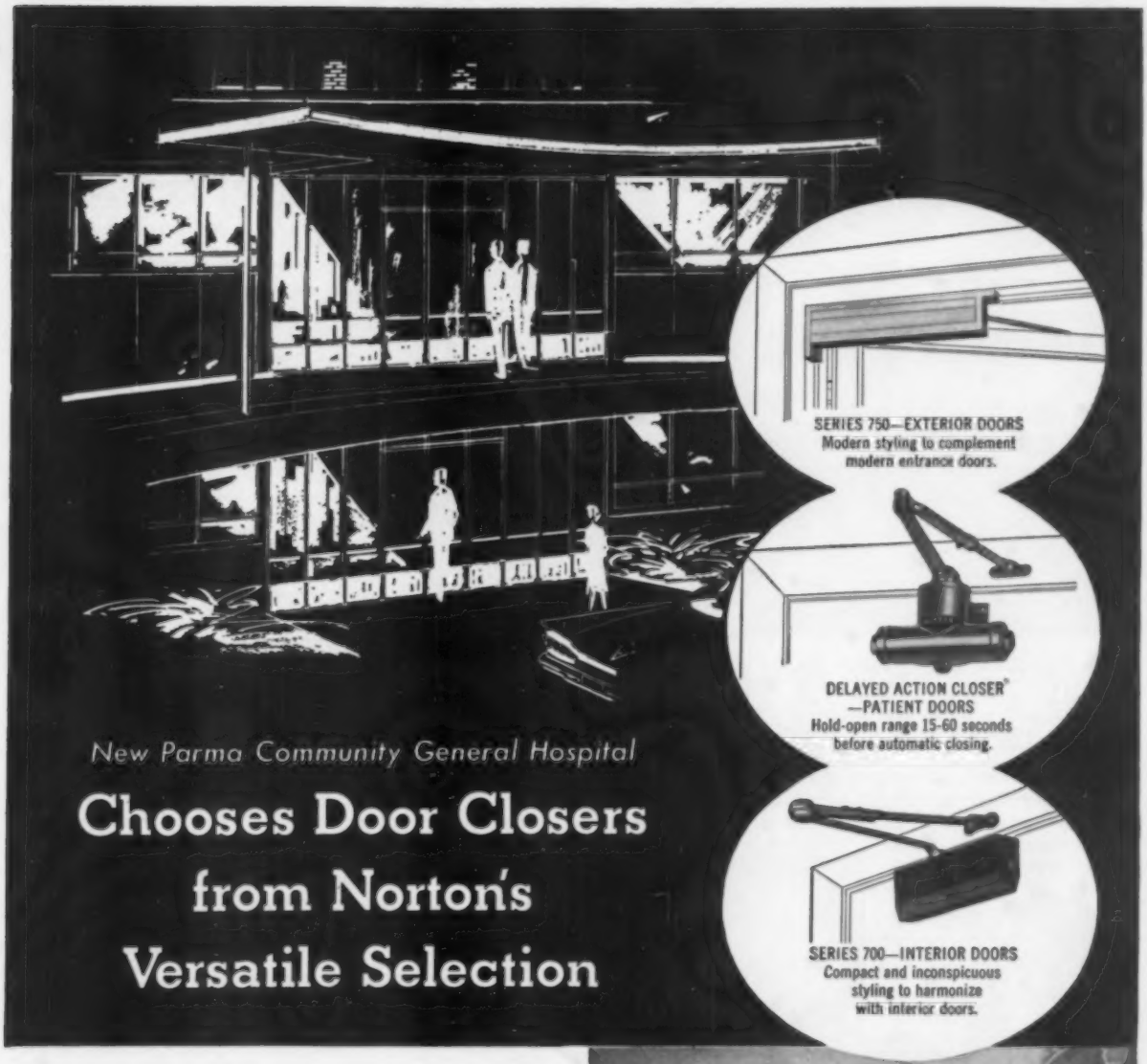
INSTRUCTOR—Medical surgical; Diploma school, affiliated with Westchester Community College B.S. degree and teaching experience required; good personnel policies; JCAH accredited 200-bed voluntary general hospital. Apply Director of Nursing, WHITE PLAINS HOSPITAL, White Plains, New York. WHite Plains 9-4500, ext 255.

LIBRARIAN—Chief medical record; $450 to $550 per month; extensive vacation and other benefits; progressive and modern Wisconsin hospital. Write to MO 339, The MODERN HOSPITAL.

LIBRARIAN—Medical records; eligible for registration, to head department within one year, in 115-bed general hospital located on the Sound in southern Connecticut; expansion program; Please send full details on qualifications and training to MO 347, The MODERN HOSPITAL.

LIBRARIAN—Registered medical records; challenging opportunity for a fully qualified medical records librarian to take over an active record department presently undergoing complete remodeling and reorganization; salary open, fully accredited 250-bed teaching, non-sectarian community hospital; approved intern resident program and schools of nursing, anesthesia and X-ray technology; $2,000,000 development program underway to provide new surgical suite, intensive care unit, psychiatric section and additional bed capacity. Apply, Personnel Director, RAVENSWOOD HOSPITAL, 1931 Wilson Avenue, Chicago 40, Illinois.

(Continued on page 162)



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LIBRARIAN—Medical record; registered; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week; salary open and commensurate with ability and experience. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

MISCELLANEOUS—Staff Nurses; nurse supervisor; psychiatric nursing instructor; salary $4,760 to $7560. Contact Chief Personnel Division, VA HOSPITAL, Knoxville, Iowa.

MISCELLANEOUS—THOMAS D. DEE MEMORIAL HOSPITAL, Ogden, Utah, 238-beds, 7 specialty departments, located in Utah's most progressive city and in the heart of the scenic west; openings available for Registered medical technologists, X-ray technicians, and several assignments for Registered nurses; attractive policies, liberal benefits and an exceptionally fine professional environment. Write or wire Director of Personnel.

NURSES—General staff; positions available in all services and on all shifts in 320-bed general hospital; starting salary $310 month with $30 differential for evenings and $20 for nights; rooms are available in the nurses' residence; The University of Arizona School of Nursing offers additional educational opportunities. Contact Assistant Director of Nursing Service, TUCSON MEDICAL CENTER, Tucson, Arizona.

NURSES—Psychiatric; staff, head nurse and supervisory positions now available; new State Mental Health Center located in a Denver suburb; high nurse-patient ratio; dynamic, interpersonal orientation; nurses an integral part of the psychiatric team; excellent opportunity for clinical experience for masters program graduates; 40-50 patient day hospital opened July, 1961; 84 inpatient unit to open winter, 1961; requires recent psychiatric nursing experience and/or graduation from a degree program; starting salaries $367, $405, $425 respectively, with 5% annual increases for five years; possibility of higher starting salary for exceptionally qualified candidates; excellent employee benefits. Write now to: Director of Nursing, FORT LOGAN MENTAL HEALTH CENTER, P. O. Box 188, Fort Logan, Colorado.

NURSES—General duty; for 320-bed JCAH accredited general hospital, only a few blocks from Lake Michigan beach and Lincoln Park; near Chicago Loop; school of nursing accredited by NLN; apartments available close to hospital; liberal personnel policies; openings on all shifts; must be eligible for Illinois registration. Write Director of Nursing, AUGUSTANA HOSPITAL, 411 W. Dickens Avenue, Chicago 14, Illinois.

NURSES—Staff; 455-bed, fully accredited general hospital adjacent to college campus; 40 hour week, 2 weeks vacation, $340 month for 3-11 & 11-7. Apply Director Nursing Service, BALL MEMORIAL HOSPITAL, Muncie, Indiana.

NURSES—Registered; opening immediately; good working conditions, 40 hour week, above average pay in modern air-conditioned hospital. Write or call Wm. C. Brickley, Administrator, PLAINVILLE RURAL HOSPITAL, Plainville, Kansas.

REHABILITATION NURSING—Rehabilitation centers for children and adults; position for staff nurses; top salaries. For information write Director of Nurses, CROTCHED MOUNTAIN FOUNDATION, Greenfield, New Hampshire.

NURSE—Operating room; wanted for 272-bed general hospital; must have OR experience; complete, new, modern operating area consisting of six operating rooms, air-conditioned with the latest modern equipment, plus 14-bed recovery room and central sterilizing; excellent salary with one of the finest nurses' personnel policies; beautiful nurses' home with all private rooms nicely furnished. If interested, write or apply DOVER GENERAL HOSPITAL, Dover, New Jersey, c/o C. T. Barker, Director.

NURSES—Registered; 994-bed Veterans Administration Neuropsychiatric Hospital opening in September; greater Cleveland area; vacancies for staff nurses, O.R. supervisors, night supervisor annual salary based on experience and education from $4,760; liberal employee benefits; new graduates appointed pending registration. Write: Personnel Officer, 10,000 Brecksville Road, Brecksville 41, Ohio.

NURSES—Registered; labor room; general staff duty; all shifts; 3-11 and 11-7 supervisor. Apply Director of Nurses, MARTINSVILLE GENERAL HOSPITAL, Martinsville, Virginia.

PHYSICIAN—Resident; Winter Park Memorial Hospital, Florida—offers an opportunity for a resident physician who will also be a member of the medical staff. For informa-

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POSITIONS OPEN

tion write President, Board of Trustees, WINTER PARK MEMORIAL HOSPITAL, Winter Park, Florida.

TECHNICIAN—Laboratory X-ray; for new 31-bed general hospital, A-1 rating, in famous Jackson Hole and Yellowstone Park area; salary commensurated with qualifications and experience. Apply MO 349, The MODERN HOSPITAL.

TECHNICIAN—Registered laboratory; A.S.C.P.; 100-bed hospital. Apply G. N. WILCOX MEMORIAL HOSPITAL, Lihue, Kauai, Hawaii.

TECHNOLOGIST — Medical; immediate opening for male or female, experienced, for 111-bed hospital in beautiful northern New Jersey; new New York City; salary excellent. Apply CHILTON MEMORIAL HOSPITAL, Pompton Plains, New Jersey.

TECHNICIAN—Laboratory; capable of taking X-ray call, A.S.C.P. preferred but not absolutely necessary; pleasant working conditions, lakes area, 45 miles north of St. Paul, Minnesota; light call schedule, paid Blue Cross family plan, top salary for the right person. Contact A. J. Thompson, Administrator, ST. CROIX VALLEY MEMORIAL HOSPITAL, St. Croix Falls, Wisconsin.

ADMINISTRATORS—(a) W/MHA, adm 600-bd full-accred gen w/further expansn planned; to $21,000; Calif. (b) W/degree adm 200-bd full accred; sal open in lge MW med center. (c) Adm 150-bd JCAH w/exc facils; liberal sal; univ twn; SE. (d) Adm 100-bd full accred now expandg 225-bds; reqs highly qual man; res suburb; MW city. (e) Adm 100-bd prop hap 100-bds to $20,000; reqs degree; Calif. (f) Asst adm 300-bd full accred gen; sal open; exc post; MW. (g) Asst adm 6 hsps in the costal area, Calif; repsons post with potential.

EXECUTIVE POSTS—(h) Bus Mngr for 520-bd JCAH; $9600 & maintenance; lovely sectn, Calif. (i) Cl Mngr, w/exper lrg grp; 20 spec; excel sal & future; W-coast (j) Pers Dir 270-bd full accred w/under way additn to 400-bds; exc sal;MW.

ANESTHETISTS—(a) 140-bed JCAH; pleasant twn in the Mid-S; to $9000. (b) 50-bds JCAH, doubling shortly; rural twn E; $8-$9000 w/$15 per/hr overtime. (c) Hd dept now being est; w/3 RN anes; 98-bds w/expansn to 150 underway; twn 10,000; S. (d) 90-bd gen w/heavy surg; 2 on staff; $700 monthly & partial maintenance; SW.

DIETITIANS—(a) Dir dept; reqs wide exper; $9-$10,000; 590-bd med schl affil gen; leadg MW city. (b) Exec dietitian; all new dept; 155-bd now expandg 210 JCAH; min $6000 & exc benefits; twn 35,000; on Miss. river. (c) Chief, pref w/tchng exper; 700-bd full accred gen; sal open; nr NYC. (d) Director; 450-bd gen ADA w/exper req; $7500 & full maint; Mid-E.

(Continued on page 164)

For additional information, use postcard facing back cover.

classified advertising

POSITIONS OPEN

WOODWARD—*Continued*

DIRECTOR OF NURSES—(a) Reqs MA, nursing adm; 86-bds now expandg 150; JCAH; exc sal; nr Los Angeles. (b) Responsible Schl w/755 students & serv; 200-bd JCAH; twn 40,000; to $8500 start; E. (c) Pref w/MS nursing; 570-bd full accred gen; min start $7500; resort area; SE. (d) Dir serv & nursing educ; reqs MS; 325-bd full accred gen; includs attractive, full main; pref w/-exper; leadg MW city.

EXECUTIVE HOUSEKEEPERS—(a) W/ degree & exper; 475-bd full accred gen; to $8300; desirable area, Calif. (b) 86 in dept; 425-bd full accred gen; req well qual; $6-$7-000; lge coll twn; MW. (c) 220-bd full accred gen; $5-$6000; nr NYC. (d) 300-bd gen; beautiful SE area; pref w/laundry exp; sal open; exc oppor.

FOOD SERVICE MANAGERS—(a) 411-bds full accred; city 100,000 lovely area Calif $8-$9700. (b) 125-in dept; full res; $7500 start; 625-bd chronic; huge Mid-E city. (c) For Coffee shop & cafe; w/some formal trng; 234-bd full accred; $550 month start; lge SW city. (d) W/degree & min 5 yrs exper; dir all phases lge psych unit; to $8800; twn 20,-000; S.

PHARMACISTS—(a) Chief; 150-bd JCAH; active dept; historic S city; $550 month start. (b) 2 in dept; 10 Mds w/24-bd hsp; $9000 & commission; exc oppor build; MW twn. (c) Dir dept, 10-MD grp w/new buildg; twn 13,-000, summer resort; MW; sal & commission; fine oppor. (d) Hd hsp pharm, 130-bds; exc sal to meet right man; fine loc, Calif.

The Medical Bureau

M. BURNICE LARSON—DIRECTOR

Telephone DElaware 7-1050

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ADMINISTRATIVE OPPORTUNITIES—(a) Administrator; growing medical research center 300 beds, excellent opport. ambitious person, MHA; E. (b) Adm; 225-bed hsp. near Chicago; top salary for proved experience. (c) Adm; brand new 150-bed convalescent home on Lake Michigan; $12-$15,000. (d) Asst. Adm; charge personnel, purch. 155-beds; near Cape Cod; salary, 2 bedroom house. (e) Adm. Asst; head hskpg. food depts. leading hsp. So; start $6-7000. (f) Controller; 400-bed hsp. near N.Y.C. $9-$12,-000. (g) Chief engineer; 200-bed hsp. plan, organize preventive mtce. near Detroit; $8,-000. (h) Food director; exceptional skill menu planning, also manage private hosp. exclusive clientele; Conn; exc. financial opport. MH 8-1.

ANESTHETISTS—(a) Free lance near San Francisco, 100-bed hsp. full coverage. (b) Sole responsibility 70-bed hsp. Texas, begin $9000. (c) Hawaii; plantation hsp. near Honolulu; $6000, apt. avail. (d) Male or female; Florida seacoast resort; 350-beds; $6000 plus call fees. MH8-2

DIETITIANS—(a) Chief; 350-bed hsp. 100 dept. personnel; no school, Florida; excellent salary; (b) Coordinate dietetic service leading pharmaceutical lab.; testing, research; start $6500; M.W. (c) Nutrition research, adm. ability head dept. 350-bed hsp. Ohio; $6-8000; MH8-3

DIRECTORS OF NURSING—(a) Overseas dir. nursing service 250 bed med. ctr; develop PN program native nurses; mountain city; Asia; $8000. (b) Direct 250 nurs. serv., N.L.N. school 125 students; 325 beds; univ. affil. hsp. overlooking lake; $11,000 plus hotel apt. M.W. (c) Dir. all grad. nrsg. staff 90 bed hsp inc. to 150 shortly; So. Calif. $7500 start; MH8-4

EXECUTIVE HOUSEKEEPER — 300-beds 80 in dept; two bldg. research ctr. E. $7500; MH8-5

MEDICAL RECORD LIBRARIANS—(a) (Chief, organize dept new hsp. 200 beds; Florida sea resort; start $6000; (b) Manage dept 100-bed hsp. near Los Angeles, $5400; need not be reg. MH8-6

OPERATING ROOM SUPERVISOR, degree, 5 yrs. exp. large So. Calif. hsp. $9000 start; MH8-7

OVERSEAS NURSES—Opportunities Public Health or B.S. teaching experience personnel; mountain city hsp. Asia; Africa, coastal, inland; tropical South Pacific island; work with natives and Americans; $5-$10,000 air travel. MH8-8

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland 15, Ohio

ADMINISTRATOR—(a) 200-bed hosp, Mass. (b) 125-bed Ohio hosp; exp program completed. (c) 50-bed Mich hosp. (d) R.N.; small southern hospital.

classified advertising

POSITIONS OPEN

INTERSTATE—*Continued*

ASSISTANT ADMINISTRATOR—(a) 300-bed Ohio hsp. (b) 100-bed Ill hosp; addition of 125-beds planned; near university city. (c) 350-bed hospital, south central state, $7500. (d) Sisters' hosp, mid-west.

PERSONNEL DIRECTOR—(a) Public relations experience preferred; degree; 375-bed Ohio hosp. (b) 250-bed Iowa hospital.

DIRECTOR, Plant maintenance; mid-west.

DIRECTOR, SCHOOL OF NURSING—(a) 400-bed eastern hospital. (b) 275-bed hosp, Ohio. (c) Nursing service; 175-bed Pa hosp. (d) 100-bed Mich. hospital.

EXECUTIVE HOUSEKEEPER — 250-bed mid-western hosp. (b) 300-bed modern hosp., east.

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ALL INQUIRIES FROM APPLICANTS ARE KEPT STRICTLY CONFIDENTIAL

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A SELECTIVE PLACEMENT BUREAU FOR MEDICAL AND HOSPITAL PERSONNEL

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Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

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MISCELLANEOUS

AUSTRALIA

THE UNIVERSITY OF NEW SOUTH WALES—CHAIR OF HOSPITAL ADMINISTRATION

The University of New South Wales invites applications for appointment to the Chair of Hospital Administration.

The successful applicant will be responsible for the administration and development of the School of Hospital Administration and all courses provided by it, including those of its Department of External Studies. The School provides a course leading to the degree of Master of Hospital Administration and a full-time extension course in Hospital Administration.

The Professor will be expected to collaborate in the work of the Faculty and serve on the Professional Board and other committees.

The salary will be £A4,292 per annum. ($9,657)

After passing a medical examination, the successful applicant will be eligible to join the State superannuation scheme, which provides for a maximum pension of £A2,184 per annum. ($4,914)

Professors are eligible for six months' study leave on full salary after three years of service or twelve months after six years of service.

Subject to the consent of the Council of the University, Professors may engage in a limited amount of higher consultative work.

With the approval of the University and its bankers, married men may be assisted by loans to purchase a home.

First-class ship fares to Sydney of appointee and his family will be paid.

The University reserves the right to fill the Chair by invitation.

Further details of conditions of appointment may be obtained from the Agent General for New South Wales from the address given below.

Four copies of applications, with the names of three referees and a recent photograph, should be lodged with the Agent General for New South Wales, 56-57 Strand, London, W.C.2, and a copy forwarded to the Appointments Section, THE UNIVERSITY OF NEW SOUTH WALES, Box 1, Post Office, Kensington, N.S.W., by airmail to arrive before 8th September, 1961.

(Continued on page 166)

classified advertising

MISCELLANEOUS

OPERATING ROOM SUPERVISOR AND CLINICAL INSTRUCTOR, O. R. Nursing (two positions)
For well-established voluntary 400-bed general hospital with two divisions, each with supervisory assistants and each with a caseload of about 450 operations a month. Seasoned staff of 44 including full-time Clinical Instructor in Operating Room Nursing. Three year diploma program with League accreditation, 100 students. Recovery rooms in each facility.

OPERATING ROOM SUPERVISORY position requires master's degree, five years of experience in operating room including teaching — supervisory responsibility or B.S. degree with equivalent experience and preferably a post graduate course in operating room nursing.

CLINICAL INSTRUCTOR, O.R. Nursing requires master's degree, five years of experience in operating room including teaching responsibility or B.S. degree in Nursing Education with experience in teaching operating room nursing.

Registration or eligibility for registration in New York State. Responsible to Director of Nursing and Administrator of Hospital. Well balanced personnel policies include four weeks' vacation, seven paid holidays, two weeks' sick leave and Cumulative sick benefits, pension plan, social security, Blue Cross, group disability and life insurance coverage scaled to salary. Salary dependent upon educational qualifications and experience. Write Director of Nursing, THE ROCHESTER GENERAL HOSPITAL, Northside Division, Rochester 21, New York.

DIRECTOR OF BUREAU OF HOSPITAL REVIEW

New York State Department of Health

Establish and carry out new State-wide program concerned with review of scope, quantity and quality of hospital care and direct studies and activities in the field of voluntary hospital insurance and medical economics.

Headquarters: Albany, New York

Salary: $18,000 with possibility of supplementation through university teaching appointment. For exceptionally qualified candidate a higher salary may be obtained.

Qualifications: M.D. Degree
Three or more years in hospital administration and planning or equivalent.
Graduate education in hospital administration or public health desirable.

Submit curriculum vitae to:

Richard H. Mattox
Director of Personnel
New York State Department of Health
84 Holland Avenue
Albany, New York

FOR SALE

The "how-to-do-it" series of articles on housekeeping technics, reprinted from the Modern Hospital, is now available in book form. Valuable teaching aid for training housekeeping employes. Write Emily C. Deming, BUTTERWORTH HOSPITAL, Grand Rapids, Mich.

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Metal or wood furniture refinished to a like new condition at your hospital. Anywhere in the Southern Hospital District.

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5802 Glenview Ave., Cincinnati 24, Ohio

SCHOOLS — SPECIAL INSTRUCTIONS

The **CHICAGO LYING-IN HOSPITAL AND DISPENSARY** of the University of Chicago offers a six-month course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 3841 Maryland Avenue, Chicago 37, Illinois.

classified advertising

SCHOOLS—SPECIAL INSTRUCTION

ST. FRANCIS HOSPITAL School of Anesthesia offers to graduates of accredited schools of nursing, an 18 months course in anesthesia. AANA accredited; approved under G.I. Bill of Rights. Stipends offered throughout course. Classes begin April 1 and October 1, each year. Write Sister M. Catherine Ann, O.S.F., C.R.N.A., Director, School of Anesthesia, ST. FRANCIS HOSPITAL, Peoria 4, Ill.

UNIVERSITY OF MICHIGAN offers an 18 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. Unlimited opportunities for endotracheal intubations, open chest, and neuro surgery anesthesia. Stipend provided. For information write "School for Nurse Anesthetists, UNIVERSITY MEDICAL CENTER, Ann Arbor, Michigan."

MT. CARMEL MERCY HOSPITAL offers an 18 month course in Anesthesiology to registered nurses of accredited schools of nursing. Approved by American Association of Nurse Anesthetists. Stipend provided. Write for complete details regarding theoretical and clinical teaching and requirements for entrance. School of Anesthesia, MT. CARMEL MERCY HOSPITAL, Detroit 35, Michigan.

BARNES HOSPITAL—Offers an 18 month post-graduate course on Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met, Miss Helen Vos, R.N., B.S., Educational Director, Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, BARNES HOSPITAL, St. Louis 10, Mo.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, PROVIDENCE LYING-IN HOSPITAL, Providence 8, Rhode Island.

WHAT'S NEW

Edited by BESSIE COVERT

LOOK inside back cover for Postage Paid inquiry card for more information.

All-Electric Hilow Bed Introduced by Hill-Rom

Listed by Underwriters Laboratories for use with oxygen administering equipment, the new Model #68 Hill-Rom all-electric Hilow Bed has all operating mechanism

fully enclosed in a neat welded frame housing. The housing top is quickly removed when necessary and there are no obstructions, such as sharp edges or racks, to impede thorough and easy cleaning.

Finger tip controls are mounted on both sides of the bed for access by patient or nurse. Any height, from 26 to 17 inches, may be had at the touch of a finger, and head and foot sections elevate to all required positions, including Trendelenburg. Recessed, bump-proof cut-out levers permit controls to be de-activated in any position. With only five electrical parts besides the 1/12 h.p. Master Motor, maintenance is reduced to a minimum.

Exposed metal parts of foot end and inner legs are covered with stainless steel, preventing the possibility of chipping or damage by mops or floor machines. Large five-inch casters are standard equipment and those at the foot end are recessed to prevent tripping. The bed will be shown at the A.H.A. convention in September. **Hill-Rom Company, Inc., Batesville, Ind.**

For more details circle #920 on mailing card.

Stainless Steel Utility Cart Has Adjustable Shelves

Shelves and casters on the new Everest & Jennings stainless steel utility cart are removable and interchangeable. Designed for exceptional strength and versatility, the cart has double-tubular corner post

construction, 14-guage steel inner posts for heavy duty rigidity and triple-process chrome plates outer post sleeves for custom spacing of shelves. The three-inch ball bearing swivel casters make it easy to handle. **Everest & Jennings, Inc., 1803 Pontius Ave., Los Angeles 25, Calif.**

For more details circle #921 on mailing card.

19 Additional Patterns in Textolite Plastic Surfacing

Ranging from dark to light colors and from plain tones to wood and marbleized effects, the 19 new Textolite patterns offer unlimited opportunities in design application. The high-pressure plastic laminate material is not only sturdy enough to resist damage when used for table and counter tops and furniture panels, but makes attractive and cheerful wall surfacing, elevator interiors, doors, paneling for corridors, washrooms, food service and entrance areas, and other purposes. The impervious material can be cleaned and sanitized by wiping with a damp cloth. Realistic wood designs are attractive for furniture and paneling, and the new Mist pattern gives a solid color effect at an economical price. **General Electric, Coshocton, Ohio.**

For more details circle #922 on mailing card.

Automatic X-Ray Processor Uses Standard Chemicals

Ready-to-read x-ray films are delivered in minutes when handled in the Rapi-Dex

Automatic X-Ray Processor. Standard chemicals are used in the completely self-contained machine, which is capable of processing up to 200 films per hour. It is simple to install, easy to operate, and will handle all standard film sizes from four by six to 14 by 17 inches. A time selector dial permits development cycles from eight to 14 minutes and temperature control can be varied from 68 to 86 degrees F. Carefully designed and engineered for minimum maintenance, the Rapi-Dex occupies less than 17 square feet of floor space. **Capitol Research Industries, Inc., 4206 Wheeler Ave., Alexandria, Va.**

For more details circle #923 on mailing card.

Bunn Asepti-Pak Technic Keeps Surgical Supplies Sterile

A completely new system for packaging common surgical supplies is offered in the Bunn Asepti-Pak Technic. Sterile surgical supplies are removed from the packaging without contamination by the sterile nurse in the operating room, after being opened by a circulating nurse. The packaging material permits proper penetration by steam or ethylene oxide in sterilization, and long shelf life with high wet strength, plus re-usable features, combine to assure economical handling. Included in the packages are glove protectors, illustrated, large and small Buckettes for small items, tubes, sponges, drains, cotton balls and the like, and catheter and Penrose drain packages. The design of the bags is such

that the sterile contents do not come in contact with any surface but a sterile one when removed in the surgery ready for use. **The John Bunn Corp., 1298 Main St., Buffalo 9, N.Y.**

For more details circle #924 on mailing card.

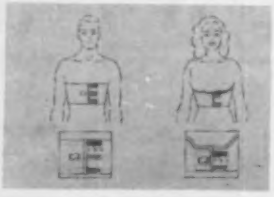
Super Floor Dressing Is Improved Mop Treatment

Super Floor Treat is a clear, light amber colored liquid described as an improved mop treatment for safe use on any type floor which has been properly sealed or treated. Used on a dust mop for a quick daily dust mopping, it will pick up dust and leave a thin, hard film which is highly resistant to black marking. It improves anti-slip properties, adds luster and extends the wearing life of wax. A special active additive makes mops easily laundered. Super Floor Treat is also available with HR-7, a powerful germicide which destroys most bacteria on contact and greatly reduces the spread of airborne bacteria. **Multi-Clean Products, Inc., 2277 Ford Parkway, St. Paul 16, Minn.**

For more details circle #925 on mailing card.

Elastic Rib Belts Have Velcro Fasteners

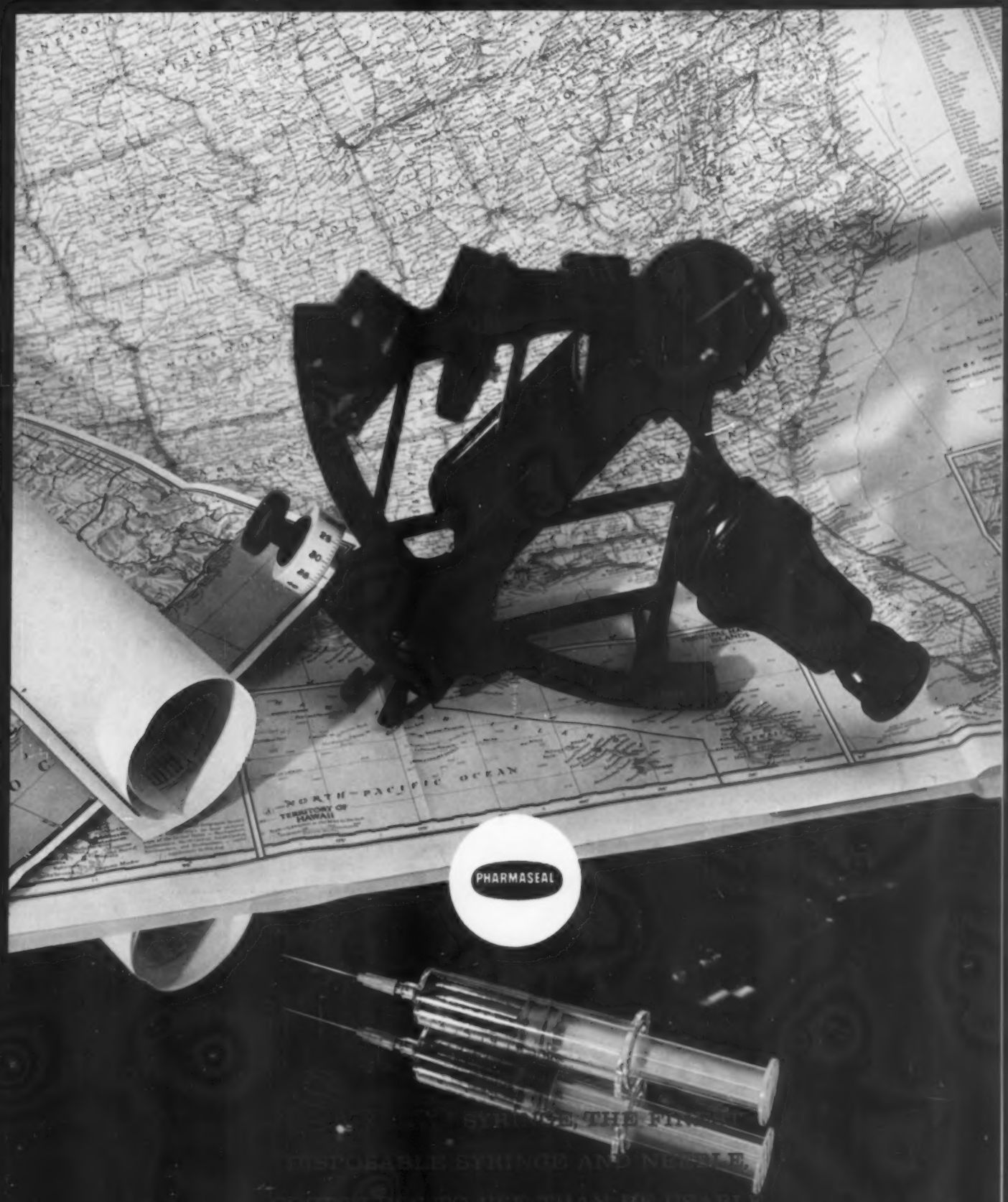
Aloe Elastic Rib Belts, manufactured of heavy, flesh-colored elastic webbing, hold firmly and comfortably at the desired position through use of Velcro touch-and-close fasteners. The closure is easy to



open or close for quick removal of the belt, and gives added patient comfort. Both male and female models come with four marks spaced 1¼ inches apart on the Velcro, to permit comfortable tension and correct positioning when reapplied. **A. S. Aloe Co., 1831 Olive St., St. Louis 3, Mo.**

For more details circle #926 on mailing card.

(Continued on page 171)



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new concepts for modern patient care

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Low-Cost Vacuum Series Features Customized Design

The Comet series of low-cost vacuums features customized design to permit matching of power unit, tank and mounting to meet individual requirements. All models are equipped with a suds suppressor, which is designed to be effective even against the highest foaming detergents, thus permitting a large wet pick-up capacity and eliminating the problem of tank overflow. The new series may be equipped

with the Microstatic Impaction Filter for 100 per cent retention of dust. **The Kent Co., Inc., Rome, N.Y.**

For more details circle #927 on mailing card.

Intracannular Cleaners Are Flexible Yet Tough

Packed in fifty-foot coils, the Weck Intracannular Cleaners are flexible, yet tough. They can be cut to the exact length required for cleaning the inside of any type of tubing and cannulas, and work on the reaming principle to effectively clean narrow and difficult areas. **Edward Weck & Co., Inc., 135 Johnson St., Brooklyn 1, N.Y.**

For more details circle #928 on mailing card.

Recording Flowmeter Shows Oxygen Charges

The NCG Recording Flowmeter, equipped with a small counter similar to an automobile mileage indicator, records the amount of oxygen used by individual patients. Billing for oxygen consumption

is simplified as the gas is registered in liters as it passes through the instrument. **National Cylinder Gas Div., 840 N. Michigan Ave., Chicago 11.**

For more details circle #929 on mailing card.

"Met-L-Pak" Faucet Control Guaranteed for Five Years

The Met-L-Pak faucet control cartridge uses no washers, packing or threads, yet provides total, friction free shut off. Unconditionally guaranteed by the manufacturer for five years, the fully tested unit operates smoothly and efficiently under any water pressure. **Universal-Rundle Corp., New Castle, Pa.**

For more details circle #930 on mailing card.

Tray Cover-of-the-Month for Patient Food Service

Six different sets of tray covers, each in four different designs, make up the AaJo Tray Cover-of-the-Month Plan recently introduced. Used for one meal each day, the covers feature two series each on Famous Americans, American Foods and American Folklore, adding interest to patient food service. Also new is a series of tent cards in seven different designs with a wide choice of imprinting options to meet individual hospital needs. One card, for use on breakfast trays, carries a pleasant morning greeting on one side with a public relations message on the back. **Aatell & Jones, Inc., 3360 Frankfort Ave., Philadelphia 34, Pa.**

For more details circle #931 on mailing card.

"D" Series Record File For Maxium Protection

The "D" Series of Visi-Shelf units is designed for maximum record protection where dirt, dust, water and fire may be factors. Incorporating the use of the exclusive Visi-Shelf drop door, all units include face-mounted reference shelves; tilting, finger-tip compressors; facile guide pulls, and individual locks and range finders. **Visi-Shelf File Inc., 105 Chambers St., New York 7.**

For more details circle #932 on mailing card.

(Continued on page 172)

Kenwood Diet Cards
Pre-Printed and Color-Coded

Designed for one time use, and as a guard against cross infection, Kenwood Diet Cards stand upright on trays without the need for holders. Available with 15 different headings, each attractive card is pre-printed and color-coded to designate the type of diet, with space for writing in the name and room number. **Will Ross, Inc., 4285 N. Port Washington Rd., Milwaukee 12, Wis.**

For more details circle #933 on mailing card.

Armosol Liquid Detergent
Kills Bacteria As It Cleans

Laboratory tests indicate complete kill at 1:80 dilution of Armosol against both gram-positive and gram-negative organisms. The liquid detergent that sanitizes, cleans and deordizes in one easy operation is especially designed for hospital use where bacteria control is a prime problem. Efficient, economical and easy to use, Armosol is the result of four years of research and field testing. It may be used with ordinary cleaning technics of sponge, mop, floor machines, spray or flood, is readily soluble in both hard and soft water, non-staining, gentle to hands and odorless, and can be used on floors, walls and equipment, including refrigerators and stoves. It is also effective for the preliminary cleaning of surgical instruments. **Armour & Co., P.O. Box 9222, Chicago 90.**

For more details circle #934 on mailing card.

Hot and Cold Food Service
for Employes at All Hours

Sixty hot-dish specialties make up the master menu for The Brass Rail automatic food service facilities. Designed to save time and costs in employe food service, while making hot and cold foods available at all hours, the automatic cafeterias for hospitals, schools, colleges and other institutions, are designed to provide pleasant dining facilities.

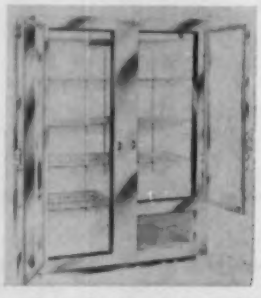
Quality meals are prepared and flash frozen for distribution throughout the

country through local franchised food service and vending operators who know the needs. The skills of superior chefs are used to provide excellent meals at low cost through high speed, assembly line restaurant production methods and the use of frozen food packaging, with vending equipment to prepare the food for immediate service as selected. The flexible machines make food and beverages available 24 hours a day, without the use of kitchen facilities. **The Brass Rail, Automatic Food Service Div., 511 Fifth Ave., New York 17.**

For more details circle #935 on mailing card.

Glass Door Models
Added To Refrigerator Line

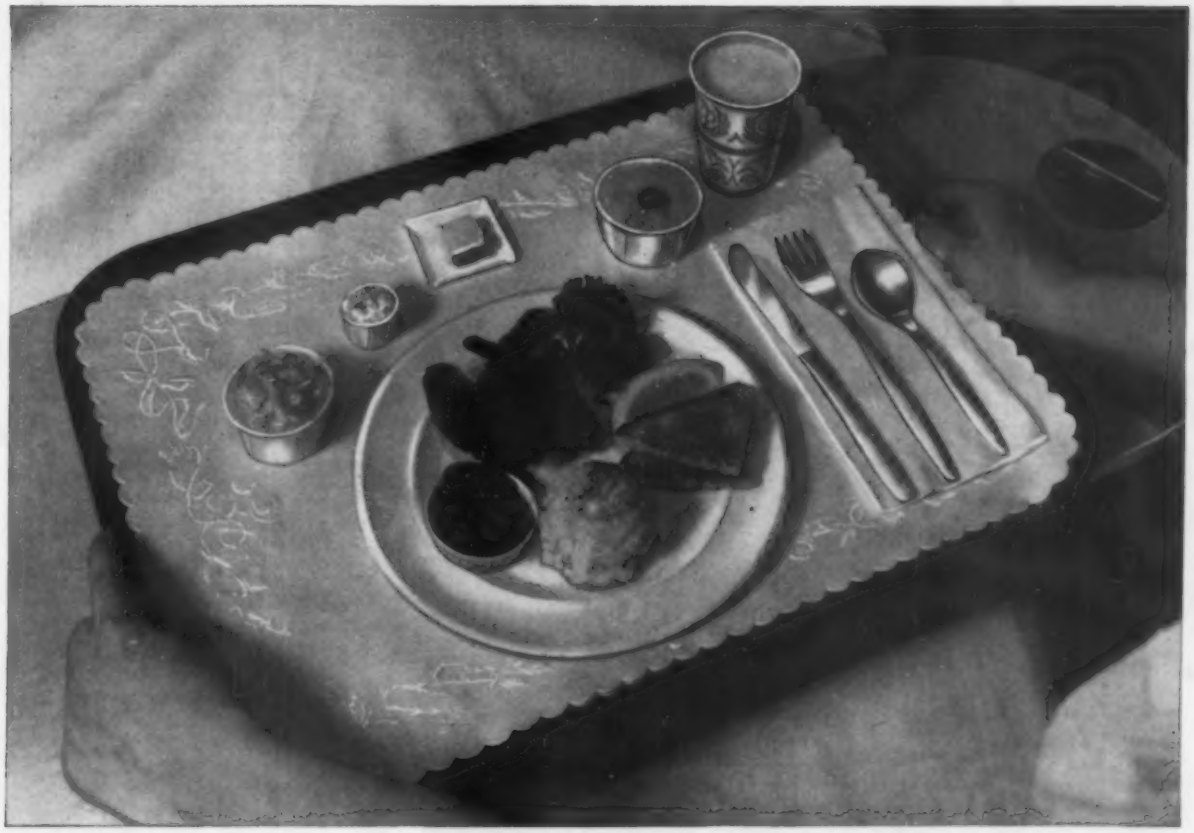
Three new glass-door models for self-contained or remote installation have been



added to the Tyler Reach-In Refrigerator line. A choice of stainless steel or baked-on white enamel is offered, and interiors are furnished with chrome plated wire shelves or pan slides. **Tyler Refrigeration Corp., Niles, Mich.**

For more details circle #936 on mailing card.

(Continued on page 174)



FEEDING PROBLEMS SOLVED...
With no Muss and very little Fuss!

When it comes to institutional feeding, minutes saved can be dollars earned . . .

Which is one big reason why so many hospitals choose Milapaco paper table accessories for time- and money-saving solutions to the increasingly complex problem of group feeding.

The facts speak for themselves! . . . With Milapaco accessories, you virtually eliminate dishwashing, speed up food handling to a marked degree. Service is always sparkling clean and spanking new, too . . . foods actually look more appetizing. And of course there's never any breakage or upkeep to worry about . . . With Milapaco, food handling is one budget item you can really trim to the bone.

Milapaco paper accessories are available in tasteful standard patterns, or may be custom-designed to your exact specifications. Fill out and mail the coupon below for samples and complete information. *Mail Coupon Now!*

CHOOSE FROM THE COMPLETE MILAPACO LINE

STOCK and SPECIAL PRINT PLACE MATS
STOCK and SPECIAL PRINT TRAY COVERS
NAPKINS, PLATES and CUPS
JELLY, PORTION and BAKING CUPS
BUTTER CHIPS

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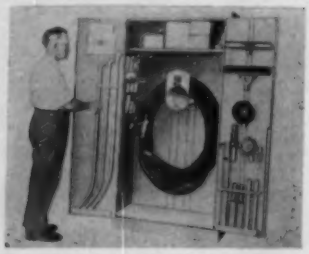
Equipment Cabinet Protects Maintenance Tools



The new U. S. Hoffman equipment cabinet for storing hose, tools, rods and vacuum cleaning equipment is fabricated of 18-gauge welded and reinforced steel with a chip resistant enamel finish. Built-in door pockets hold operator and maintenance instructions, as well as a series of illustrated tool sheets that provide easy identification. **U. S. Hoffman Machinery Corp., 103 4th Ave., New York 3.**

For more details circle #937 on mailing card.

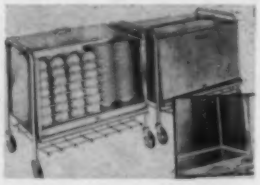
Improved Poly-Kote Is Water Emulsion Floor Coating

Improved Poly-Kote floor polish, a clear, non-yellowing, synthetic, water emulsion coating, produces a long lasting high gloss finish and can be buffed after cleaning to restore original lustre. Tracked-in water or water spillage presents no hazard because the surface becomes more non-skid when wet. Built-in resistance to soil, water spotting, traffic marking and scuffing makes Poly-Kote practical for all flooring, and traffic lanes can be patched and blended in without recoating the entire floor. **Hillyard Chemical Co., 403 N. 3rd St., St. Joseph 1, Mo.**

For more details circle #938 on mailing card.

T-170SU Dish Caddy Has Rounded Interior

The T-170SU Caddy, designed for use with cups, glasses or dishes, features rounded and coved interior corner construction for easier handling of dishes and



improved sanitation. The unit is made of all welded stainless steel, with or without translucent plastic covers. Those with covers are available with an electric heating unit. **Caddy Corp. of America, 1625 Paterson Plank Rd., Secaucus, N. J.**

For more details circle #939 on mailing card.

Rackless Conveyor-Type Washer Handles 13,000 Dishes Per Hour

Eacon polypropylene, with high chemical resistance, and strength and rigidity under load and high service temperatures, is used on the automatic conveyor of the new Jackson 16Z3 rackless conveyor-type dishwasher. Capable of handling up to 13,000 dishes per hour, the new machine has advance design features and is offered in different models which permit feeding from either the right or the left side. A removable scrap drawer at the input of the three-cycle machine eliminates the

need for complete pre-scrapping of dishes, and an automatic cut-off plate at the unloading end stops the conveyor if dishes are not removed, ensuring against accidental breakage. All pre-wash, wash and rinse jets are readily accessible for cleaning. **The Jackson Products Co., Industrial Park, Tampa 4, Fla.**

For more details circle #940 on mailing card.

Pre-Sweetened Oat Cereal Has High Protein Content

A vitamin-enriched oat cereal with protein content said to be as efficient as that of milk or meat is introduced by Quaker Oats. Called Life, the pre-sweetened oat cereal is in bite-size, shredded form. **The Quaker Oats Co., 345 Merchandise Mart, Chicago 54.**

For more details circle #941 on mailing card.

(Continued on page 176)

Lavatory Unit Is Attractively Priced

The Fermont, a newly designed porcelain enameled cast-iron lavatory unit, features attractive design with economy. Modern styling includes a low back with tapered ends and a rectangular basin with front overflow. The Fermont is furnished for wall hanging or chair carrier mounting, with Dialese or Crestmont brass trim. **Crane Co., P.O. Box 780, Johnstown, Pa.**

For more details circle #942 on mailing card.

Three-Position Switch Produces Two Light Levels

Two levels of lighting are achieved for single-filament lamp bulbs with the new General Electric High/Low Control. The three-position switch operates lamps at full brightness in the high position, at 30 per cent brightness in the low position, and turns the lamp off in center position. The switch is insensitive to loads and will control several incandescent lamps of the same or different wattages within a 300-watt maximum limit. **General Electric Co., Wiring Device Dept., Providence 7, R.I.**

For more details circle #943 on mailing card.

Magnetic Cards Key To Memory File

Card Random Access Memory is a unique memory file which can instantly select any desired records from a maze of information not necessarily organized into alphabetical or numerical sequence. It utilizes a new device, a deck of 256 plastic magnetic cards, to preserve essential data. Information can be selected from any card in one-sixth of a second. **National Cash Register Co., S. Main & K Sts., Dayton 9, Ohio.**

For more details circle #944 on mailing card.

Germax Floor Wax Kills Bacteria

Containing the new wax-compatible bactericide-bacteristat Sepsen, Germax floor wax kills bacteria and provides maximum protection. It is a high quality, non-skid, water-resistant, self-polishing wax which buffs to a high luster and remains bacteristatic even after weeks of damp moppings and hard traffic. A new plastic floor finish, which is scuff and slip resistant and also contains Sepsen, is offered in Plastisept. Extensive laboratory tests show the ability of Sepsen to destroy antibiotic-resistant staphylococcus aureus upon contact. **National Chemsearch Corp., 2417 Commerce, Dallas 26, Tex.**

For more details circle #945 on mailing card.

Sterneedle Gun for Multiple Punctures

Developed to simplify mass tuberculin testing, the Sterneedle Gun is an improved multiple puncture apparatus for rapid intradermal testing. Six needles contained in the Sterneedle cartridge are mechanically and painlessly driven into the skin through a previously applied film of a stabilized solution of tuberculin P.P.D. The automatic device, with disposable Sterneedle cartridges, permits up to 350 tests per hour, saves time and costs,

requires no dressings and gives accurate interpretation, without measurement. **The Panray Corp., 266 S. Dean St., Englewood, N.J.**

For more details circle #946 on mailing card.

(Continued on page 178)

Floor Machine
Converts for All Uses

The Clarke Model FM-13R Shampoo Machine has a floating nylon brush which self-adjusts on its caster base to provide the exact pressure for gentle, thorough and safe shampooing of rugs and carpets.

The caster base cradle and shampoo brush are easily removed, providing a conventional floor machine which employs various types of brushes and pads for scrubbing, polishing, waxing, steel wooling and buffing. **Clarke Floor Machine Co., 30 E. Clay Ave., Muskegon, Mich.**

For more details circle #947 on mailing card.

Barnstead Distilled Water System
Ensures Sufficient Supply

Described as a new better way to produce and store distilled water, the Barnstead system is designed specifically to meet the needs of the modern hospital. It provides enough distilled water for all hospital services during peak use periods; keeps distilled water chemically pure, pyrogen free and sterile in storage; eliminates maintenance and cleaning of water still and bottles, and provides water of maximum purity, suitable for all hospital needs, including laboratory research. The system includes a hospital still, purifier equipment, fully automatic controls, ultraviolet equipment, Ventgard air filter and self-closing faucet. It is offered in models to fit the need of hospitals of every size. **Barnstead Still & Sterliizer Co., 2 Lanesville Terrace, Boston 31, Mass.**

For more details circle #948 on mailing card.

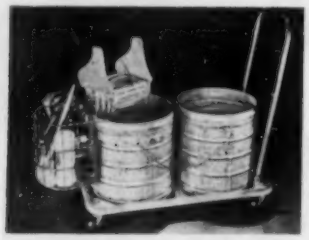
"Stand-Alone" Aid
For Paraplegics

"Stand-Alone" Therapeutic Aid, developed by a paralyzed veteran, enables the patient to achieve a standing position unassisted, after which the vehicle is motivated as easily as a wheel chair. The "Stand-Alone" is easy to get into, will not tip over, gives correct adjustable support for standing, and folds compactly for transporting. **Jean Medical Products Sales Co., 447 Hidalgo Ave., Alhambra, Calif.**

For more details circle #949 on mailing card.

(Continued on page 180)

Mop Bucket With Task-Basket Is Complete Cleaning Unit



The Task-Basket, a new wire basket which fits over the side of an eight or 11-gallon mop bucket, is designed to hold most tools and materials needed for cleaning operations. By stocking it with spot-remover, extra cloths and similar equipment, time-consuming trips back to the supply closet can often be avoided. The open mesh design assures full ventilation and quick selection of items desired. **Geerpres Wringer, Inc., P. O. Box 658, Muskegon, Mich.**

For more details circle #950 on mailing card.

Three Rinse Additives For Varied Dishwashing Systems

Three new drying agents for use as rinse additives in machine dishwashing have been introduced to meet the demands of any water or operating condition: Jet Dry, for above average conditions; Rinse Dry, for normal conditions, and Heavy Duty Rinse Dry, for difficult conditions. Studies indicate that tableware is washed in water ranging from 20 to 1,000 ppm total dissolved solids, and the three additives are designed to compensate for these variations. **Economics Laboratory, Inc., 250 Park Ave., New York 17.**

For more details circle #951 on mailing card.

Carmody Portable Aspirator Is Vacuum-and-Pressure Unit

The Carmody Electric Aspirator is now available in the new Starline Super-60 Series. The portable vacuum-and-pressure unit with Recirculating Oil System is more efficient and dependable than previ-

ous models for bedside and some surgical procedures. It is simple, quiet and strong, the pumps require only infrequent lubrication, and equipment includes vacuum gauge, vacuum control valve, safety trap, efficient filter, standard quart vacuum bottle and on-off switch. **V. Mueller & Co., 33 S. Honore St., Chicago 12.**

For more details circle #952 on mailing card.

Refrigerator and Heat Cabinet for Food on Racks

Available in two, three or four sections, the combination refrigerator and heat cabinet for food on racks has a capacity of 31 pans in each section. The unit can be placed on an existing floor without an insulated bottom, thus eliminating the necessity for recessing the base. Temper-

atures can be maintained in the refrigerated sections as low as 38 degrees and in the hot section, which is controlled by a thermostat, up to 200 degrees. **C. Schmidt Co., 1712 John St., Cincinnati 14, Ohio.**

For more details circle #953 on mailing card.

Linen Inspection Table Is Cool to Operate

Illuminated from beneath by fluorescent lighting, the Hausmann Linen Inspection Table provides for easy and positive inspection of operating room packs, sterile and non-sterile linen. The sturdily constructed table is cool to operate, has an illuminated section 9 by 51 inches in size, and the switch is mounted on the right side of the table apron. **W. R. Hausmann Woodwork, Inc., 1545 Inwood Ave., New York 52.**

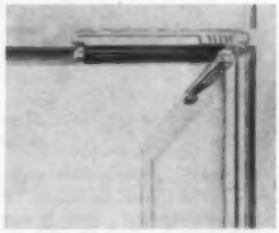
For more details circle #954 on mailing card.

Dualsound Foldoor Provides Double Insulation

The improved Dualsound Foldoor provides the protection of two sound-insulated partitions and the operating convenience of a single unit. Exclusive construction consists of two narrow profile, Multi-V Foldoors joined by a single lead post to operate as one partition. Two kinds of improved insulation material reduce sound transmission by both reflecting and absorbing action and thus assure quiet in flexibly partitioned rooms. **Holcomb & Hoke Mfg. Co., Inc., Dept. 818, 1545 Van Buren St., Indianapolis 7, Ind.**

For more details circle #955 on mailing card.

Headliner Door Control Is Concealed Overhead



Headliner Concealed Overhead Door Control offers highly efficient door control for any doorway head jamb or transom bar as slim as 1¾ by 4½ inches, in any type building. No visible hinges, closers, arms or holders interrupt the clean lines of door or frames, even when the door is open. **Dor-O-Matic Div., Republic Industries, Inc., 7350 W. Wilson, Chicago 31.**

For more details circle #956 on mailing card.

Plastic Male Urinal Designed to Reduce Spilling

A deep sump receives urine without fear of flowback in the new plastic male urinal. The special design with an unusually low center of gravity reduces the hazard of spilling or tipping over. The smooth molded contours and handle make it easy to use and the plastic makes it

warm to the touch, chip and dent proof, unbreakable and quiet. It is graduated in ounces, pints and c.c., will not stain or retain urine odors and can be safely autoclaved. **Plastic-Medic Mfg., Inc., 10 W. Dayton St., Pasadena, Calif.**

For more details circle #957 on mailing card.

(Continued on page 182)

For additional information, use postcard facing back cover.

Aluminum Dolly Has Increased Mobility

The improved Erecta-Shelf dolly is now formed of aluminum for strength with

light weight. The unit is easily handled, has plastisol bumpers, and the sturdy rubber casters are smooth and silent. **Metropolitan Wire Goods Corp., N. Washington St. & George Ave., Wilkes-Barre, Pa.**
For more details circle #958 on mailing card.

Disposable Plastic Shroud Has Hood and Ties

A new opaque shroud garment made of Impervite plastic is fully disposable and has hood and ties attached. The plastic has a soft, linen-like finish, is pliant and durable and impervious to fluids. It resists tearing, thus giving full protection, and

lends itself to adjusting and handling. It is low in cost, providing the price advantage of paper with the waterproof durability of plastic. **Busse Hospital Disposables, Inc., 64 E. Eighth St., New York 3.**
For more details circle #959 on mailing card.

Tough Plastic Container Has Many Uses

Advantages for use in the laboratory, in surgery and at the bedside are indicated for the new Falcon 4½-ounce polypropylene covered container. The tough, pliable jar is virtually inert to all common chemicals, and transparent for visual observation and many colorimetric determinations. The polyethylene snap-lock closure makes it safe for use in collecting specimens in surgery or wards for transporta-

tion to the laboratory. The cup itself may be autoclaved, resists low temperature, and is permeable to oxygen and other gases. It may also be used at the bedside for children, senile and psychiatric cases since it can be dropped or thrown without damage. **Falcon Plastics, Div. of B-D Laboratories, Inc., 5510 W. 83rd St., Los Angeles 45, Calif.**
For more details circle #960 on mailing card.

Airkem A-3 Cleaning Solution In "Pfsst" Container

"Pfsst" is the descriptive name given to the new six-ounce, non-breakable plas-

tic spray container for Airkem A-3 Cleaning Solution. A-3 is sprayed on doors, walls, furniture and other surfaces and wiped with a damp cloth to clean, disinfect and kill odors, and it leaves a residual air-freshened effect on any surface that requires immediate, but non-routine, spot cleaning. **Airkem Inc., 241 E. 44th St., New York 17.**

For more details circle #961 on mailing card.

Silverware Handling Cylinder Sets in Three Positions

Steril-Sil Tri-Lok is the name of a new three-position cylinder for handling silverware which holds all silver sizes and is molded of tough Derlin in a design to

assure free drainage. The down position spreads the silver for washing efficiency, a mid-range position is used for dispensing of short pieces, and the fully extended position is for tumbling, transporting and dispensing of standard silver. **Steril-Sil Co., 150 Causeway St., Boston 14, Mass.**

For more details circle #962 on mailing card.

D-Tarnish Cleaning Agent Restores Luster to Silver

D-Tarnish cleaning and brightening agent keeps silverware lustrous and tarnish-free with only a few minutes of soaking periodically. **DuBois Chemicals, Inc., Broadway at 7th, Cincinnati 2, Ohio.**

For more details circle #963 on mailing card.

Stainless Steel Fountains In Several Models

Included in the new line of stainless steel drinking fountains introduced by

Halsey Taylor are face-mounted wall-types as well as counter-type fixtures. All units in the line feature modern appearance, ease of maintenance and lifetime service. **Halsey W. Taylor Co., Warren, Ohio.**

For more details circle #964 on mailing card.

(Continued on page 184)

Pharmaceuticals

Poliomyelitis Vaccine Aluminum Phosphate Adsorbed

A new type of poliomyelitis vaccine, requiring a smaller dose, is now available from Parke, Davis. Poliomyelitis Vaccine, Aluminum Phosphate Adsorbed requires injections of only 0.5 cc. as compared with 1 cc. for the first fluid-type polio vaccine. Other advantages of the new vaccine include reduced extraneous protein, very low residual antibiotic concentration, and antibody response at least comparable to the fluid-type vaccine. The new product may be used either for the complete immunizing series or as a booster. **Parke, Davis & Co., Jos. Campau at the River, Detroit 32, Mich.**

For more details circle #965 on mailing card.

Pediatric Piptal Antipyretic

A new product designed for the relief of the fever, pain and spasm associated with gastrointestinal disturbances in infants and children, Pediatric Piptal Antipyretic is formulated in a solution for administration by dropper or mixed with milk, formula or fruit juice. **Lakeside Laboratories, Inc., 1707 E. North Ave., Milwaukee 2, Wis.**

For more details circle #966 on mailing card.

LE-Test

A simple slide screening test for detecting antinuclear factors in active systemic lupus erythematosus, LE-Test employs a reagent prepared from polystyrene latex and desoxyribonucleoprotein. Field trials of LE-Test have demonstrated that it is simple to perform and to interpret, offering the advantages to the technician of simplicity, speed, clarity and specificity. **Hyland Laboratories, 4501 Colorado Blvd., Los Angeles 39, Calif.**

For more details circle #967 on mailing card.

Haldrone

A new oral corticosteroid of marked potency and high anti-inflammatory effect, Haldrone is approximately ten time as potent as hydrocortisone. Clinical tests show it to be well tolerated, with low incidence of significant untoward reactions. Haldrone is indicated for steroid-responsive conditions. It is supplied in both one and two mg. scored tablets for precise individual dosage. **Eli Lilly & Co., 740 S. Alabama St., Indianapolis 6, Ind.**

For more details circle #968 on mailing card.

Parnate

Parnate is a relatively fast-acting drug for the symptomatic treatment of mental depression. An unusually potent monoamine oxidase inhibitor, Parnate is not a hydrazine derivative and clinical studies indicate only occasional postural hypotension, restlessness and insomnia as side effects. Parnate is indicated to relieve symptoms which may include dejection, self-depreciation, decreased activity, difficulty in making decisions and disturbed eating and sleeping patterns. **Smith, Kline & French Laboratories, 1530 Spring Garden St., Philadelphia 1, Pa.**

For more details circle #969 on mailing card.

Dimocillin

A new synthetic antibiotic with unique effectiveness against resistant staphylococcal infections is offered in Squibb Dimocillin. Synthesized from a fermentation product, Dimocillin's antistaphylococcal action has been confirmed through lengthy clinical experience. **E. R. Squibb & Sons, 745 Fifth Ave., New York 22.**

For more details circle #970 on mailing card.

Buclamase

Buclamase is a buccal tablet containing 10 mg. of the enzyme alpha amylase with 1250 Rystan Units of amylolytic activity per mg. It is indicated in the management of inflammation, edema and pain in traumatic athletic injuries, surgical conditions, allergic states, connective tissue disorders and dental and EENT conditions. It acts upon the buccal membrane to initiate a physiologic compensatory response to inflammation anywhere in the body. **Rystan Co., 7 N. Macquesten Pkwy., Mount Vernon, N.Y.**

For more details circle #971 on mailing card.

Enarax 5

A new dosage form of Enarax, used in treating peptic ulcer and other gastrointestinal disorders, is offered in Enarax 5, containing 5 mg. of oxyphencyclimine where the earlier product contains 10 mg. Future packages of the more potent 10 mg. product will carry the label Enarax 10. **Chas. Pfizer & Co., 800 Second Ave., New York 17.**

For more details circle #972 on mailing card.

(Continued on page 186)

Literature and Services

• A new **Kreiselman and E & J Resuscitator Catalog** is now available from Ohio Chemical & Surgical Equipment Co., Madison 10, Wis. The first half of the 20-page booklet is devoted to units that employ the Kreiselman principle of manual intermittent positive pressure, while the second half describes and illustrates units which operate on the E & J principle of automatic positive-negative pressure.
For more details circle #973 on mailing card.

• Five items recently added to its line of **laboratory ware** are described in a bulletin issued by Fischer & Porter Co., 855 Jacksonville Rd., Warminster, Pa.
For more details circle #974 on mailing card.

• **Buckso Mobile Service Equipment** is the subject of a new catalog offered by Bucks County Enterprises, Inc., Quakertown, Pa. The complete line of Temper-Luminum mobile service equipment is included and each product page faces a page with complete specifications and a detailed dimensional sketch of the equipment described.
For more details circle #975 on mailing card.

• Improved models of the current line of **Explosion-Proof Refrigerators** manufactured by Kelmore, Inc., 599 Springfield Ave., Newark 3, N.J., and listed by Underwriters Laboratories, are included in the new specification sheet and descriptive brochure recently released.
For more details circle #976 on mailing card.

• **"Hand Chased Bronze Tablets, Plaques and Signs"** are the subject of a new 12-page illustrated brochure giving descriptive information on the line manufactured by A. J. Bayer Co., 2300 E. Slauson Ave., Los Angeles 58, Calif.
For more details circle #977 on mailing card.

• The "Most Useful Professional Texts for Hospital Administrators, Staff Members, Nurses and Medical Record Librarians" available from Physicians' Record Co., 3000 S. Ridgeland Ave., Berwyn, Ill., are listed in a recent **Book List, Circular 1570-H.**
For more details circle #978 on mailing card.

• Attractive, practical hospital interiors are discussed with illustrations in the new comprehensive **Hospital Planning Guide Book** showing how to use Victrex V.E.F. Wallcoverings. Available from L. E. Carpenter & Co., Inc., Empire State Bldg., New York 1, the booklet describes the economy of Vicrtex V.E.F. and gives information regarding the colors and textures available to provide cheerful surroundings.
For more details circle #979 on mailing card.

• A comprehensive 44-page catalog, entitled **"A Guide to the Selection of American-Standard Plumbing Products for Hospital Installations,"** is now available from American-Standard sales offices or the Plumbing & Heating Div., 40 W. 40th St., New York 18. The booklet shows selected plumbing products from the American-Standard line of hospital fixtures, and gives details of their general and special applications in various hospital areas. Floor plans and general descriptions of hospital areas, with products suggested, are included.
For more details circle #980 on mailing card.

• The complete line of Lyon steel equipment for institutions and industry is described and illustrated in a new 100-page general **Catalog No. 100-K.** Available from Lyon Metal Products, Inc., 1 Plant Ave., Aurora, Ill., the book describes several new products shown for the first time, including a complete line of office chairs, a new bookcase and Lyon Slotted Angle and accessories.
For more details circle #981 on mailing card.

• **Catalog #6013-H** on aluminum windows for commercial and institutional buildings contains photographs of actual installations to illustrate the appearance achieved by selected designers. The 36-page catalog, published by Ceco Steel Products Corp., 5601 W. 26th St., Chicago 50, contains easy-to-use section and installation details with suggested architects specifications.
For more details circle #982 on mailing card.

• **Three new catalogs** are offered by Cutlet Metal Products Co., 1925 Pine St., Camden 3, N.J., including a 16-page brochure on Toilet Compartments, Hospital Cubicles, Dressing Enclosures and Urinal Screens; a six-page Shower Cabinet Brochure, and a four-page brochure of Cutler Receptors. Specifications, engineering details, illustrations and descriptive information are included.
For more details circle #983 on mailing card.

(Continued on page 188)

Carefully built for
CAREFREE *beauty*

CHEMCLAD®

PLASTIC LAMINATE DOORS

947 Chemclad Doors have been custom made for Cobo Hall, Detroit, Mich. Architects and Engineers: Giffels & Rossetti, Inc.

From core to surface, custom-built Chemclad Doors are carefully constructed for a lifetime of *carefree* beauty. All doors are covered with Chemclad's extra thick, high-impact plastic laminate in a wide choice of beautiful wood grains and colors. Optional features include: Integral scuff plates, louvers, stainless steel edge angles, etc. Confidence is a built-in plus factor, too, because every Chemclad Door carries the full warranty of the most experienced manufacturer in the field. See us in Sweet's—or write for full details.

Representatives in Principal Cities from Coast to Coast.

BOURNE
MANUFACTURING COMPANY
1573 E. Larned Street • Detroit, Michigan

"Hospital designed" Maysteel casework

planned to reduce labor costs

You can install space-saving Maysteel storage cabinets closer to work area — for step-saving, time-saving without sacrificing corridor space. And they're easier to use, quieter in operation, simpler to keep clean inside and outside, provide more storage room per square feet of floor space. Check *all* the advantages of Maysteel "Hospital Designed" Casework.

"HOSPITAL DESIGNED" FINISH . . .

More than beauty and color, Maysteel Baked Enamel finishes are porcelain-like in their hardness and resistance to abrasion and cleaning solvents — for years of like-new appearance.

"HOSPITAL DESIGNED" FOR QUIETNESS

Solid, double-paneled doors and drawers, sound-deadened, with silent hinges, rollers, slides or soft rubber bumpers — provide for quiet operation of every moving part of Maysteel Casework

"HOSPITAL DESIGNED" REACHING HEIGHT

Your linens, blankets, instruments, supplies are *always* within easy reach — in Maysteel "Hospital Designed" Storage Cabinets. Every cabinet proportion is reach-checked for ready convenience.

"HOSPITAL DESIGNED" for MORE STORAGE IN LESS SPACE

From 10% to 40% more storage space per square foot of floor space — is a Maysteel engineering achievement that means valuable space-economy to modern hospital planning. Look for this advantage in all Maysteel Casework.

MAYSTEEL PRODUCTS, INC.
738 Horicon St., Mayville, Wisconsin

☐ Send New Maysteel Catalog and Planning Guide
☐ Give us name of nearest Maysteel representative

Name .....
Address .....
City ..... State .....
Attn. of .....

For additional information, use postcard facing back cover.

• **The Orthomatic Sterilizer Control System** of Wilmot Castle Co., 1946 E. Henrietta Rd., Rochester, N.Y., is described in the eight-page **Bulletin H268.** Features of the sterilizing system are discussed, and closely-detailed photographs of the sterilizer control panel components complement graphs comparing Orthomatic operation with that of conventional sterilizers.
For more details circle #984 on mailing card.

• An unusual science film, which makes visible to the naked eye the **"Destruction of Living Human Cells by Virus Invasion,"** is available to the profession from Doho, 100 Varick St., New York 13. The full color sound film is designed for showing to professional and study groups exceeding 20 persons in hospitals and universities.
For more details circle #985 on mailing card.

• Complete test reports and construction details on Spectra-Glaze concrete masonry units are presented in a **16-page technical brochure** and file folder available from Burns & Russell Co., Box 6063, Baltimore 31, Md.
For more details circle #986 on mailing card.

• The 1961 edition of the **"Interior Fire Fighting Equipment Catalog" (Form No. S-62FPB)** is now available from The Fyr-Fyter Co., 221 Crane St., Dayton 1, Ohio. The 16-page book, revised annually, provides complete and current information on all the line of portable-type interior fire safety equipment supplied by the company for use in hospitals, schools and other commercial and institutional buildings.
For more details circle #987 on mailing card.

• **Hospital Catalog No. 13** comprehensively reviews the expanded line of hospital products offered by The Sterilon Corp., 500 Northland Ave., Buffalo 11, N.Y. Specific details are given on solution and blood sets, feeding and drainage tubes, pediatric products and catheters, as well as the new disposable items, such as surgical scalpels, forceps and catheterization and prep sets.
For more details circle #988 on mailing card.

• The complete line of **Surgical and Nursing Instruments, Equipment and Supplies** offered by Max Wocher & Son Co., 609 College St., Cincinnati 2, Ohio, is cataloged in a 354-page book recently released. Descriptive information and illustrations of the extensive line are included, and the catalog is carefully indexed.
For more details circle #989 on mailing card.

• A new 44-page catalog available from Bel-Art Products, Industrial Rd., Pequannock, N.J., lists the complete line of plastic laboratory ware for science and industry manufactured by the company.
For more details circle #990 on mailing card.

Book Announcements

Bleier, "Maternity Nursing — A Textbook for Practical Nurses," 159 pp., $2.75. Brown and Fowler, "Psychodynamic Nursing — A Biosocial Orientation," 2nd ed., 315 pp., $4.50. Cady, "Nursing in Tuberculosis," 2nd ed., 489 pp., $6.50. Carpenter, "Microbiology," 432 pp., $6.75. Fischer, "A Basic Course in the Theory and Practice of Quantitative Chemical Analysis," 2nd ed., 501 pp., $6.75. Jones, "Experimental Chemistry for Student Nurses," 115 pp., $3.75. Marlow and Sellew, "Textbook of Pediatric Nursing," 750 pp., $7.50. **W. B. Saunders Co., Washington Square, Philadelphia 5, Pa.**
For more details circle #991 on mailing card.

Suppliers' News

American Sterilizer Co, Erie, Pa., manufacturer of hospital and surgical equipment, announces the purchase of **Excel Metal Cabinet Co., Jamestown, N.Y.,** manufacturer of enameled and stainless steel casework and cabinets for hospitals and institutions. Excel will continue its operations as a wholly-owned Amsco subsidiary, according to the announcement.

Aseptic-Thermo Indicator Co., 11471 Vanowen St., North Hollywood, Calif., manufacturer of indicator products and sterilization bags, announces completion of a large new addition to its plant. The new space will accommodate the enlarged Research Department and expanding facilities, with increased plant capacity for standard and newly developed products.

Helene Curtis Industries, Inc., Chicago, announces acquisition of **Pyramid Rubber Co., Ravenna, Ohio,** manufacturer and distributor of **Evenflo** baby feeding equipment, nurses, bottles, nipples and related accessories. Included in the acquisition are five subsidiaries or affiliates of Pyramid Rubber, manufacturing glass, plastic and rubber components of its products. The announcement states that there will be no changes in personnel or policies of Pyramid.

INDEX TO ADVERTISEMENTS

USE THIS PAGE TO REQUEST PRODUCT INFORMATION

The index on this and the following page lists advertisements in this magazine alphabetically by manufacturer. For additional information about any product or service advertised, circle the manufacturer's key number on the detachable postcard and mail it. No postage is required.

Products described in the "What's New" pages of this magazine also have key numbers which appear in each instance following the description of the item. For more information about these items, circle the appropriate numbers on the postcard and mail it, without postage, to The Modern Hospital.

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USE THIS CARD — (We pay the postage)

I am interested in the items circled— **August, 1961**

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NAME _____ TITLE _____

INSTITUTION _____

ADDRESS _____ ZONE _____ STATE _____

☐ **Enter my One Year Subscription To Modern Hospital ($5), Foreign ($7)**

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(HPF) after company name indicates that further descriptive data are filed in catalog space in Hospital Purchasing File 1961 Edition.

(190)

*New Product Announcement

a significant achievement in corticosteroid research

HALDRONE™

(paramethasone acetate, Lilly)

Æsculapius

Haldrone is a potent synthetic corticosteroid with marked anti-inflammatory activity. In steroid-responsive conditions, it provides predictable anti-inflammatory effects with a minimum of untoward reactions. Gratifying response has been observed in patients transferred from other corticosteroids to Haldrone. There is relatively little adverse effect on electrolyte metabolism. With Haldrone, sodium retention is unlikely, psychic effects are minimal, and there appears to be freedom from muscle weakness and cramping.

Haldrone, 2 mg., is approximately equivalent to	Cortisone	25 mg.
	Hydrocortisone	20 mg.
	Prednisone or prednisolone	5 mg.
	Triamcinolone or methylprednisolone	4 mg.
	Dexamethasone	0.75 mg.

Although the incidence of significant side-effects is low, the usual contraindications to corticosteroid therapy apply to Haldrone.

Supplied in bottles of 30, 100, and 500	Tablets Haldrone, 1 mg., Yellow (scored)
	Tablets Haldrone, 2 mg., Orange (scored)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

140-48

CERAMAFLEX®... *newest development of Romany•Spartan research. Sixty-four ceramic mosaic tiles securely bonded in a resilient rubber grid, pre-grouted and laid quickly and inexpensively in 9" squares. Quiet and comfortable underfoot. Choose from 12 attractive Buckshot® patterns for installation over any sound sub-floor above, on or below grade.*

Plate No. 2004

Plate No. 2005

Romany • Spartan provides extra cleanliness wherever food is prepared or served.

Plate No. 2007

Washroom walls and floors of Romany• Spartan stay fresh and clean with little care.

eye-appealing...
enduring...
easily maintained...

Plate No. 2006

Ceramaflex is ideal in lobby and corridors– attractive, quiet and comfortable underfoot.

Plate No. 2008

Operating room floors of Romany•Spartan conductive tile add an extra margin of safety.

...floors and walls of Romany•Spartan

The use of ceramic tile throughout the hospital offers many well known advantages, but when you choose Romany•Spartan you get even more. There's Level-Set® glazed wall tile in a complete range of beautiful colors. Level-Set is edge-ground, the world's *only* precisely sized 4¼" wall tile. This means extra setting speed, and because of its thin, straight joints–the most attractive installation you've ever seen.

Then there's Ceramaflex®, the world's *only* resilient ceramic floor covering. Ceramaflex gives you all the advantages of ceramic floor tile, yet it's soft and quiet underfoot. There are glazed and unglazed ceramic mosaics, too, in a myriad of patterns and designs, back-mounted for faster installation. Consult your architect. He can show you samples and provide more information. United States Ceramic Tile Company, Dept. MH-22. Canton 2, Ohio.

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